

110TH CONGRESS  
1ST SESSION

# S. 1019

To provide comprehensive reform of the health care system of the United States, and for other purposes.

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IN THE SENATE OF THE UNITED STATES

MARCH 28, 2007

Mr. COBURN (for himself, Mr. BURR, Mr. CHAMBLISS, and Mr. INHOFE) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To provide comprehensive reform of the health care system of the United States, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Universal Health Care Choice and Access Act”.

6 (b) TABLE OF CONTENTS.—The table of contents for  
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

### TITLE I—PREVENTION AND WELLNESS

Sec. 101. Strategic approach to outcome-based prevention.

- Sec. 102. State grants for outcome-based prevention effort.
- Sec. 103. Keeping the food stamp program focused on nutrition.
- Sec. 104. Immunizations.

## TITLE II—TAX INCENTIVES TO ENCOURAGE PURCHASE OF HEALTH CARE INSURANCE

### Subtitle A—Health Savings Accounts

- Sec. 201. Expansion of health savings accounts.
- Sec. 202. Exception to requirement for employers to make comparable health savings account contributions.

### Subtitle B—MediChoice Tax Rebates

- Sec. 211. Refundable credit for health insurance coverage.
- Sec. 212. Advance payment of credit for purchasers of qualified health insurance.
- Sec. 213. Termination of employer-provided health care coverage exclusion.

## TITLE III—HEALTH INSURANCE MODERNIZATION

### Subtitle A—Employee Choice

- Sec. 301. Clarification of definition of group health plan under HIPAA.

### Subtitle B—Access to Health Care

- Sec. 311. State high risk pools.
- Sec. 312. Federally qualified health centers.

### Subtitle C—Interstate Market for Health Insurance

- Sec. 321. Short title.
- Sec. 322. Specification of constitutional authority for enactment of law.
- Sec. 323. Findings.
- Sec. 324. Cooperative governing of individual health insurance coverage.
- Sec. 325. Severability.

## TITLE IV—IMPROVEMENTS TO THE MEDICARE PROGRAM

### Subtitle A—MediChoice for Seniors

- Sec. 401. Setting the benchmark equal to the national average bid.
- Sec. 402. Enhancement of beneficiary rebates.
- Sec. 403. Alternative benefit design to original medicare fee-for-service benefits.
- Sec. 404. Medicare advantage HSA plans.
- Sec. 405. Review of adjustment mechanism used under the Medicare Advantage program.

### Subtitle B—Enhancements to the Medicare Fee-For-Service Program

- Sec. 411. Elimination of annual indexing of income thresholds for reduced part B premium subsidies.
- Sec. 412. Authority to adjust amount of Medicare part B premium to reward positive health behavior.
- Sec. 413. Recapture of Medicare DSH funds.
- Sec. 414. Price transparency requirements for Medicare providers.

Subtitle C—Value-Based Purchasing

- Sec. 421. Repeal of physician ownership referral prohibitions based on compensation arrangements.
- Sec. 422. Revision of designated health services subject to ownership referral prohibition.
- Sec. 423. Exceptions to ownership referral prohibitions.
- Sec. 424. Effective date.

Subtitle D—Securing Medicare’s Future for Tomorrow’s Seniors

- Sec. 431. Medical Retirement Accounts.

TITLE V—KEEPING MEDICAID ON MISSION

- Sec. 501. Restructuring of Medicaid funding.
- Sec. 502. Medicaid Advantage program.
- Sec. 503. High performance bonuses.

TITLE VI—ADMINISTRATIVE HEALTH CARE TRIBUNALS

- Sec. 601. State grants to create administrative health care tribunals.

TITLE VII—HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

- Sec. 701. Purpose.
- Sec. 702. Health record banking.
- Sec. 703. Application of Federal and State security and confidentiality standards.

Subtitle B—Promoting the Use of Health Information Technology to Better Coordinate Health Care

- Sec. 711. Safe harbors to antikickback civil penalties and criminal penalties for provision of health information technology and training services.
- Sec. 712. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training services to health care professionals.
- Sec. 713. Rules of construction regarding use of consortia.

TITLE VIII—MISCELLANEOUS

- Sec. 801. Dedication of Medicaid and revenue savings to strengthening the financial solvency of the Federal Hospital Insurance Trust Fund.
- Sec. 802. Health care choice for veterans.
- Sec. 803. Health care choice for Indians.

**1 SEC. 2. FINDINGS.**

**2** Congress makes the following findings:

1           (1) Nine out of 10 Americans think the United  
2       States health care system needs fundamental  
3       changes.

4           (2) The United States spends approximately 16  
5       percent of its Gross Domestic Product on health  
6       care and experts estimate that percentage will rise  
7       to 20 percent by 2015.

8           (3) The Federal Government spends more on  
9       health care than it does on national defense.

10          (4) As much as \$1 out of every \$4 health care  
11       dollars do not go towards making Americans  
12       healthy.

13          (5) Nearly 75 percent of American health care  
14       spending goes toward the treatment of chronic dis-  
15       eases. Five preventable chronic diseases (heart dis-  
16       ease, cancer, stroke, chronic obstructive pulmonary  
17       disease, and diabetes) cause two-thirds of American  
18       deaths.

19          (6) Since 2000, premiums for family health cov-  
20       erage have increased by 87 percent, compared with  
21       cumulative inflation of 18 percent and cumulative  
22       wage growth of 20 percent. During this same period,  
23       the percentage of employers offering health benefits  
24       has fallen from 69 percent to 61 percent, and the  
25       percentage of workers covered by their own employer

1       also has fallen. The current employer-based system  
2       offers little choice in health plans to employees: 88  
3       percent of American firms offer only 1 health plan  
4       type.

5           (7) Medicaid was designed as a safety net to  
6       ensure that the poorest Americans have access to  
7       health care at a cost of \$1,000,000,000 in its first  
8       year. Today, more than 1 out of every 6 Americans  
9       is in Medicaid at a total cost of more than  
10      \$338,000,000,000 in 2006. The program is expected  
11      to cost nearly \$5,000,000,000,000 over the next dec-  
12      ade. In 2003, for the first time ever, Medicaid  
13      spending replaced education as the largest compo-  
14      nent of State budgets, consuming 22 percent of  
15      State spending.

16          (8) The unfunded liabilities of the Medicare  
17      Program over the next 75 years are estimated to be  
18      \$32,100,000,000,000 and \$70,500,000,000,000 on  
19      the infinite horizon. The Federal Hospital Insurance  
20      Trust Fund is projected to be exhausted by 2018.  
21      Without any change in the program, Medicare will  
22      consume 23.1 percent of all Federal income taxes by  
23      2020 and 37.5 percent of all Federal income taxes  
24      by 2030. Under the current system, physician reim-  
25      bursements will be cut by 34 percent by the year

2015, leading to decreased access to physicians’ services for seniors.

(9) Our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care. Economists estimate that between 5 and 9 percent of health care spending is related to defensive medicine.

(10) The adoption of health information technology will significantly reduce health care spending while simultaneously increasing the quality of health care.

## **TITLE I—PREVENTION AND WELLNESS**

### **SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.**

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the “Secretary”) shall convene an interagency coordi-

1 nating committee to develop a national strategic  
2 plan for prevention. The Secretary shall serve as the  
3 chairperson of the committee.

4 (2) COMPOSITION.—In carrying out paragraph  
5 (1), the Secretary shall include the participation  
6 of—

7 (A) the Director of the National Institutes  
8 of Health;

9 (B) The Director of the Centers for Dis-  
10 ease Control and Prevention;

11 (C) the Administrator of the Agency for  
12 Healthcare Research and Quality;

13 (D) the Administrator of the Substance  
14 Abuse and Mental Health Services Administra-  
15 tion;

16 (E) the Administrator of the Health Re-  
17 sources and Services Administration;

18 (F) the Secretary of Agriculture;

19 (G) the Director of the Centers for Medi-  
20 care & Medicaid Services;

21 (H) the Administrator of the Environ-  
22 mental Protection Agency;

23 (I) the Director of the Indian Health Serv-  
24 ice;

1 (J) the Administrator of the Administra-  
2 tion on Aging;

3 (K) the Secretary of Veterans Affairs;

4 (L) the Secretary of Defense;

5 (M) the Secretary of Education; and

6 (N) the Secretary of Labor.

7 (3) REPORT AND PLAN.—Not later than 1 year  
8 after the date of enactment of this Act, the Sec-  
9 retary, acting through the coordinating committee  
10 convened under paragraph (1), shall submit to Con-  
11 gress a report concerning the recommendation of the  
12 committee for health promotion and disease preven-  
13 tion activities. Such report shall include a specific  
14 strategic plan that shall include—

15 (A) a list of national priorities on health  
16 promotion and disease prevention to address  
17 lifestyle behavior modification (smoking ces-  
18 sation, proper nutrition, and appropriate exer-  
19 cise) and the prevention measures for the 5  
20 leading disease killers in the United States;

21 (B) specific science-based initiatives to  
22 achieve the measurable goals of Healthy People  
23 2010 regarding nutrition, exercise, and smoking  
24 cessation, and targeting the 5 leading disease  
25 killers in the United States;



1 (C) specific plans for consolidating Federal  
2 health programs and Centers that exist to pro-  
3 mote healthy behavior and reduce disease risk  
4 (including eliminating programs and offices de-  
5 termined to be ineffective in meeting the pri-  
6 ority goals of Health People 2010), that include  
7 transferring the nutrition guideline development  
8 responsibility from the Secretary of Agriculture  
9 to the Director of the Centers for Disease Con-  
10 trol and Prevention;

11 (D) specific plans to ensure that all Fed-  
12 eral health care programs are fully coordinated  
13 with science-based prevention recommendations  
14 promulgated by the Director of the Centers for  
15 Disease Control and Prevention;

16 (E) specific plans to ensure that all non-  
17 Department of Health and Human Services  
18 prevention programs are based on the science-  
19 based guidelines developed by the Centers for  
20 Disease Control and Prevention under subpara-  
21 graph (D); and

22 (F) a list of new non-Federal and non-gov-  
23 ernment partners identified by the committee to  
24 build Federal capacity in health promotion and  
25 disease prevention efforts.

1 (4) ANNUAL REQUEST TO GIVE TESTIMONY.—

2 The Secretary shall annually request an opportunity  
3 to testify before Congress concerning the progress  
4 made by the United States in meeting the outcome-  
5 based standards of Healthy People 2010 with re-  
6 spect to disease prevention and measurable outcomes  
7 and effectiveness of Federal programs related to this  
8 goal.

9 (5) PERIODIC REVIEWS.—The Secretary shall  
10 conduct periodic reviews, not less than every 5 years,  
11 and grading of every Federal disease prevention and  
12 health promotion initiatives, programs, and agencies.  
13 Such reviews shall be evaluated based on effective-  
14 ness in meeting metrics-based goals with an analysis  
15 posted on such agencies' public Internet websites.

16 (b) FEDERAL MESSAGING ON HEALTH PROMOTION  
17 AND DISEASE PREVENTION.—

18 (1) MEDIA CAMPAIGNS.—

19 (A) IN GENERAL.—Not later than 1 year  
20 after the date of enactment of this Act, the Sec-  
21 retary, acting through the Director of the Cen-  
22 ters for Disease Control and Prevention, shall  
23 establish and implement a national science-  
24 based media campaign on health promotion and  
25 disease prevention.

1 (B) REQUIREMENTS OF CAMPAIGN.—The  
2 campaign implemented under subparagraph  
3 (A)—

4 (i) shall be designed to address proper  
5 nutrition, regular exercise, smoking ces-  
6 sation, obesity reduction, the 5 leading dis-  
7 ease killers in the United States, and sec-  
8 ondary prevention through disease screen-  
9 ing promotion;

10 (ii) shall be carried out through com-  
11 petitively bid contracts awarded to entities  
12 providing for the professional production  
13 and design of such campaign;

14 (iii) may include the use of television,  
15 radio, Internet, and other commercial mar-  
16 keting venues and may be targeted to spe-  
17 cific age groups based on peer-reviewed so-  
18 cial research;

19 (iv) shall not be duplicative of any  
20 other Federal efforts relating to health  
21 promotion and disease prevention; and

22 (v) may include the use of humor and  
23 nationally-recognized positive role models.

24 (C) EVALUATION.—The Secretary shall en-  
25 sure that the campaign implemented under sub-

1 paragraph (A) is subject to an independent  
2 evaluation every 2 years and shall report every  
3 2 years to Congress on the effectiveness of such  
4 campaigns towards meeting science-based  
5 metrics.

6 (2) WEBSITE.—The Secretary, in consultation  
7 with private-sector experts, shall maintain or enter  
8 into a contract to maintain an Internet website to  
9 provide science-based information on guidelines for  
10 nutrition, regular exercise, obesity reduction, smok-  
11 ing cessation, and specific chronic disease preven-  
12 tion. Such website shall be designed to provide infor-  
13 mation to health care providers and consumers.

14 (3) DISSEMINATION OF INFORMATION  
15 THROUGH PROVIDERS.—The Secretary, acting  
16 through the Centers for Disease Control and Preven-  
17 tion, shall develop and implement a plan for the dis-  
18 semination of health promotion and disease preven-  
19 tion information consistent with national priorities  
20 described in the strategic and implementing plan  
21 under subsection (a)(3)(A), through health care pro-  
22 viders who participate in Federal programs, includ-  
23 ing programs administered by the Indian Health  
24 Service, the Department of Veterans Affairs, the De-  
25 partment of Defense, and the Health Resources and

1 Services Administration, and the Medicare and Med-  
2 icaid Programs.

3 (4) PERSONALIZED PREVENTION PLANS.—

4 (A) CONTRACT.—The Secretary, acting  
5 through the Director of the Centers for Disease  
6 Control and Prevention, shall enter into a con-  
7 tract with a qualified entity for the development  
8 and operation of a Federal Internet website  
9 personalized prevention plan tool.

10 (B) USE.—The website developed under  
11 subparagraph (A) shall be designed to be used  
12 as a source of the most up-to-date scientific evi-  
13 dence relating to disease prevention for use by  
14 individuals. Such website shall contain a compo-  
15 nent that enables an individual to determine  
16 their disease risk (based on personal health and  
17 family history, BMI, and other relevant infor-  
18 mation) relating to the 5 leading diseases in the  
19 United States, and obtain personalized sugges-  
20 tions for preventing such diseases.

21 (5) INTERNET PORTAL.—The Secretary shall  
22 establish an Internet portal for accessing risk-assess-  
23 ment tools developed and maintained by private and  
24 academic entities.

1           (6) PRIORITY FUNDING.—Funding for the ac-  
2           tivities authorized under this section shall take pri-  
3           ority over funding from the Centers for Disease Con-  
4           trol and Prevention provided for grants to States  
5           and other entities for similar purposes and goals as  
6           provided for in this section. Not to exceed  
7           \$500,000,000 shall be expended on the campaigns  
8           and activities required under this Act.

9   **SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVEN-**  
10                   **TION EFFORT.**

11           (a) IN GENERAL.—If the Secretary determines that  
12           it is essential to meeting the national priorities described  
13           in the plan required under section 101(a)(3)(A), the Sec-  
14           retary may award grants to States for the conduct of spe-  
15           cific health promotion and disease prevention activities.

16           (b) ELIGIBILITY.—To be eligible to receive a grant  
17           under subsection (a), a State shall submit to the Secretary  
18           an application at such time, in such manner, and con-  
19           taining such information as the Secretary may require, in-  
20           cluding a strategic plan that shall—

21                   (1) describe the specific health promotion and  
22           disease prevention activities to be carried out under  
23           this grant;

1           (2) include a list of the barriers that exist with-  
 2           in the State to meeting specific goals of Healthy  
 3           People 2010;

4           (3) include targeted demographic indicators and  
 5           measurable objectives with respect to health pro-  
 6           motion and disease prevention;

7           (4) contain a set of process outcomes and mile-  
 8           stones, based on the process outcomes and mile-  
 9           stones developed by the Secretary, for measuring the  
 10          effectiveness of activities carried out under the grant  
 11          in the State; and

12          (5) outline the manner in which interventions to  
 13          be carried out under this grant will reduce morbidity  
 14          and mortality within the State over a 5-year period  
 15          (or over a 10-year period, if the Secretary deter-  
 16          mines such period appropriate for adequately meas-  
 17          uring progress).

18          (c) PROCESS OUTCOMES AND MILESTONES.—

19               (1) IN GENERAL.—The Secretary shall develop  
 20               process outcomes and milestones to be used to meas-  
 21               ure the effectiveness of activities carried out under  
 22               a grant under this section by a State.

23               (2) DETERMINATIONS.—If, beginning 2 years  
 24               after the date on which a grant is awarded to a  
 25               State under this section, the Secretary determines

1       that the State is failing to make adequate progress  
2       in meeting the outcomes and milestones contained in  
3       the State plan under subsection (b)(4), the Secretary  
4       shall provide the State with technical assistance on  
5       how to make such progress. Such technical assist-  
6       ance shall continue for a period of 2 years.

7           (3) CONTINUED FAILURE TO MEET OBJEC-  
8       TIVES.—If after the expiration of the 2-year period  
9       described in paragraph (2), the Secretary determines  
10      that the State is failing to make adequate progress  
11      in meeting the outcomes and milestones contained in  
12      the State plan under subsection (b)(4) over a 5-year  
13      period, the Secretary shall terminate all funding to  
14      the State under a grant under this section.

15      (d) REGIONAL ACTIVITIES.—A State may use an  
16      amount, not to exceed 15 percent of the total grant  
17      amount to such State, to carry out regional activities in  
18      conjunction with other States.

19      (e) TARGETED ACTIVITIES.—A State may use grant  
20      funds to target specific populations within the State to  
21      achieve specific outcomes described in Healthy People  
22      2010.

23      (f) INNOVATIVE INCENTIVE STRUCTURES.—The Sec-  
24      retary may award grants to States for the purposes of de-  
25      veloping innovative incentive structures to encourage indi-



1 viduals to adopt specific prevention behaviors such as re-  
 2 ducing their body mass index or for smoking cessation.

3 (g) WELLNESS BONUSES.—

4 (1) IN GENERAL.—The Secretary shall award  
 5 wellness bonus payments to at least 5, but not more  
 6 than 10, States that demonstrate the greatest  
 7 progress in reducing disease rates and risk factors  
 8 and increasing healthy behaviors.

9 (2) REQUIREMENT.—To be eligible to receive a  
 10 bonus payment under paragraph (1), a State shall  
 11 demonstrate—

12 (A) the progress described in paragraph  
 13 (1); and

14 (B) that the State has met a specific floor  
 15 for progress outlined in the science-based  
 16 metrics of Healthy People 2010.

17 (3) USE OF PAYMENTS.—Bonus payments  
 18 under this subsection may only be used by a State  
 19 for the purposes of health promotion and disease  
 20 prevention.

21 (4) FUNDING.—Out of funds appropriated to  
 22 the Director of the Centers for Disease Control and  
 23 Prevention for each fiscal year beginning with fiscal  
 24 year 2008, the Director shall give priority to using

1       \$50,000,000 of such funds to make bonus payments  
2       under this subsection.

3       (h) ADMINISTRATIVE EXPENSES.—A State may use  
4       not more than 5 percent of the amount of a grant under  
5       this section to carry out administrative activities.

6       (i) STATE.—In this section, the term “State” means  
7       the 50 States, the District of Columbia, the Common-  
8       wealth of Puerto Rico, Guam, Samoa, the United States  
9       Virgin Islands, and the Commonwealth of the Northern  
10      Mariana Islands.

11      (j) AUTHORIZATION OF APPROPRIATIONS.—Funding  
12      for the activities authorized under this section shall take  
13      priority over funding from the Centers for Disease Control  
14      and Prevention provided for grants to States and other  
15      entities for similar purposes and goals as provided for in  
16      this section, not to exceed \$300,000,000 for each fiscal  
17      year.

18      **SEC. 103. KEEPING THE FOOD STAMP PROGRAM FOCUSED**  
19                                      **ON NUTRITION.**

20      (a) COUNSELING BROCHURE.—The Director of the  
21      Centers for Disease Control and Prevention shall develop,  
22      and the Secretary of Agriculture shall distribute to each  
23      individual and family enrolled in the Food Stamp Program  
24      under the Food Stamp Act of 1977 (7 U.S.C. 2011 et  
25      seq.), a science-based nutrition counseling brochure.

1 (b) LIMITATIONS ON FOOD STAMP PURCHASES.—

2 (1) IN GENERAL.—Not later than 6 months  
3 after the date of enactment of this Act, the Sec-  
4 retary of Agriculture shall, based on scientific, peer-  
5 reviewed recommendations provided by a Commis-  
6 sion that includes public health, medical, and nutri-  
7 tion experts and the Director of the Centers for Dis-  
8 ease Control and Prevention, develop lists of foods  
9 that do not meet science-based standards for proper  
10 nutrition and that may not be purchased under the  
11 food stamp program. Such list shall be updated on  
12 an annual basis to ensure the most current science-  
13 based recommendations are applied to the food  
14 stamp program.

15 (2) AUTOMATED ENFORCEMENT.—The Sec-  
16 retary of Agriculture shall, through regulations, en-  
17 sure that the limitations on food purchases under  
18 paragraph (1) is enforced through the food stamp  
19 program’s automated system.

20 (3) IMPLEMENTATION.—The Secretary of Agri-  
21 culture shall promulgate the regulations described in  
22 paragraph (2) by the date that is not later than 1  
23 year after the date of enactment of this section.

1 **SEC. 104. IMMUNIZATIONS.**

2 (a) PURCHASE OF VACCINES.—Notwithstanding any  
3 other provision of law, a State may use amounts provided  
4 under section 317 of the Public Health Service Act (42  
5 U.S.C. 247b) for immunization programs to purchase vac-  
6 cines for use in health care provider offices and schools.

7 (b) TECHNICAL ASSISTANCE AND REDUCTION IN  
8 FUNDING.—If a State does not achieve a benchmark of  
9 80 percent coverage within the State for Centers for Dis-  
10 ease Control and Prevention-recommended vaccines, the  
11 Director of the Centers shall provide technical assistance  
12 to the State for a period of 2 years. If after the expiration  
13 of such 2-year period the State continues to fail to achieve  
14 such benchmark, the Secretary shall reduce funding pro-  
15 vided under section 317 of the Public Health Service Act  
16 to such State by 5 percent.

17 (c) BONUS GRANT.—A State achieving a benchmark  
18 of 90 percent or greater coverage within the State for Cen-  
19 ters for Disease Control and Prevention-recommended  
20 vaccines shall be eligible for a bonus grant from amounts  
21 appropriated under subsection (d).

22 (d) AUTHORIZATION OF APPROPRIATIONS.—Out of  
23 funds appropriated to the Director of the Centers for Dis-  
24 ease Control and Prevention for each fiscal year beginning  
25 with fiscal year 2008, there shall be made available to  
26 carry out this section, \$50,000,000 for each fiscal year.

1 (e) FUNDING FOR SECTION 317.—Section 317(j)(1)  
 2 of the Public Health Service Act (42 U.S.C. 247b(j)(1))  
 3 is amended by striking “2005” and inserting “2010”.

4 **TITLE II—TAX INCENTIVES TO**  
 5 **ENCOURAGE PURCHASE OF**  
 6 **HEALTH CARE INSURANCE**

7 **Subtitle A—Health Savings**  
 8 **Accounts**

9 **SEC. 201. EXPANSION OF HEALTH SAVINGS ACCOUNTS.**

10 (a) INCREASE IN MONTHLY CONTRIBUTION LIMIT.—

11 (1) IN GENERAL.—Paragraph (2) of section  
 12 223(b) of the Internal Revenue Code of 1986 (relat-  
 13 ing to limitations) is amended to read as follows:

14 “(2) MONTHLY LIMITATION.—

15 “(A) IN GENERAL.—In the case of an eligi-  
 16 ble individual who has coverage under a high  
 17 deductible health plan, the monthly limitation  
 18 for any month of such coverage is  $\frac{1}{12}$  of the  
 19 sum of—

20 “(i) the greater of—

21 “(I) the sum of the annual de-  
 22 ductible and the other annual out-of-  
 23 pocket expenses (other than for pre-  
 24 miums) required to be paid under the

plan by the eligible individual for covered benefits, or

“(II) in the case of an eligible individual who has—

“(aa) self-only coverage under a high deductible health plan as of the first day of such month, \$2,250, or

“(bb) family coverage under a high deductible health plan as of the first day of such month, \$4,500, and

“(ii) in the case of an eligible individual who has coverage under a qualified long-term care insurance contract (as defined in section 7702B(b)), the lesser of—

“(I) the annual premium for such coverage, or

“(II) \$1,000.

“(B) SPECIAL RULES RELATING TO OUT-OF-POCKET EXPENSES.—

“(i) REDUCTION FOR SEPARATE PLAN.—The annual out-of-pocket expenses taken into account under subparagraph (A)(i)(I) with respect to any eligible indi-

vidual shall be reduced by any out-of-pocket expense payable under a separate plan covering the individual.

“(ii) SECRETARIAL AUTHORITY.—The Secretary may by regulations provide that annual out-of-pocket expenses will not be taken into account under subparagraph (A)(i)(I) to the extent that there is only a remote likelihood that such amounts will be required to be paid.”.

(2) APPLICATION OF SPECIAL RULES FOR MARRIED INDIVIDUALS.—Paragraph (5) of section 223(b) of such Code (relating to limitations) is amended to read as follows:

“(5) SPECIAL RULES FOR MARRIED INDIVIDUALS.—

“(A) IN GENERAL.—In the case of individuals who are married to each other and who are both eligible individuals, the limitation under paragraph (1) for each spouse shall be equal to the spouse’s applicable share of the combined marital limit.

“(B) COMBINED MARITAL LIMIT.—For purposes of subparagraph (A), the combined marital limit is the excess (if any) of—

1 “(i) the lesser of—

2 “(I) subject to subparagraph (C),  
3 the sum of the limitations computed  
4 separately under paragraph (1) for  
5 each spouse (including any additional  
6 contribution amount under paragraph  
7 (3)), or

8 “(II) the dollar amount in effect  
9 under subsection (c)(2)(A)(ii)(II),  
10 over

11 “(ii) the aggregate amount paid to  
12 Archer MSAs of such spouses for the tax-  
13 able year.

14 “(C) SPECIAL RULE WHERE BOTH  
15 SPOUSES HAVE FAMILY COVERAGE.—For pur-  
16 poses of subparagraph (B)(i)(I), if either spouse  
17 has family coverage which covers both spouses,  
18 both spouses shall be treated as having only  
19 such coverage (and if both spouses each have  
20 such coverage under different plans, shall be  
21 treated as having only family coverage with the  
22 plan with respect to which the lowest amount is  
23 determined under paragraph (2)(A)(i)(I)).

24 “(D) APPLICABLE SHARE.—For purposes  
25 of subparagraph (A), a spouse’s applicable



1 share is  $\frac{1}{2}$  of the combined marital limit unless  
 2 both spouses agree on a different division.

3 “(E) COUPLES NOT MARRIED ENTIRE  
 4 YEAR.—The Secretary shall prescribe rules for  
 5 the application of this paragraph in the case of  
 6 any taxable year for which the individuals were  
 7 not married to each other during all months in-  
 8 cluded in the taxable year, including rules  
 9 which allow individuals in appropriate cases to  
 10 take into account coverage prior to marriage in  
 11 computing the combined marital limit for pur-  
 12 poses of this paragraph.”.

13 (3) SELF-ONLY COVERAGE.—Paragraph (4) of  
 14 section 223(c) of such Code (relating to definitions  
 15 and special rules) is amended to read as follows:

16 “(4) COVERAGE.—

17 “(A) FAMILY COVERAGE.—The term ‘fam-  
 18 ily coverage’ means any coverage other than  
 19 self-only coverage.

20 “(B) SELF-ONLY COVERAGE.—If more  
 21 than 1 individual is covered by a high deduct-  
 22 ible health plan but only 1 of the individuals is  
 23 an eligible individual, the coverage shall be  
 24 treated as self-only coverage.”.

25 (4) CONFORMING AMENDMENTS.—

1 (A) Section 223(b)(3)(A) of such Code is  
 2 amended by striking “subparagraphs (A) and  
 3 (B) of”.

4 (B) Section 223(d)(1)(A)(ii)(I) of such  
 5 Code is amended by striking “subsection  
 6 (b)(2)(B)(ii)” and inserting “subsection  
 7 (c)(2)(A)(ii)(II)”.

8 (C) Clause (ii) of section 223(c)(2)(D) of  
 9 such Code is amended to read as follows:

10 “(ii) CERTAIN ITEMS DISREGARDED  
 11 IN COMPUTING MONTHLY LIMITATION.—  
 12 Such plan’s annual deductible, and such  
 13 plan’s annual out-of-pocket limitation, for  
 14 services provided outside of such network  
 15 shall not be taken into account for pur-  
 16 poses of subsection (b)(2).”

17 (D) Subsection (g) of section 223 of such  
 18 Code is amended to read as follows:

19 “(g) COST-OF-LIVING ADJUSTMENT.—

20 “(1) IN GENERAL.—In the case of any taxable  
 21 year beginning in a calendar year after 2008, each  
 22 dollar amount contained in subsections (b)(2)(A)  
 23 and (c)(2)(A) shall be increased by an amount equal  
 24 to—

25 “(A) such dollar amount, multiplied by

1 “(B) the cost-of-living adjustment deter-  
 2 mined under paragraph (2) for the calendar  
 3 year in which such taxable year begins.

4 “(2) COST-OF-LIVING ADJUSTMENT.—For pur-  
 5 poses of paragraph (1), the cost-of-living adjustment  
 6 for any calendar year is the percentage (if any) by  
 7 which—

8 “(A) the GDP for the preceding calendar  
 9 year, exceeds

10 “(B) the GDP—

11 “(i) for calendar year 1997, in the  
 12 case of each dollar amount in subsection  
 13 (b)(2)(A)(i),

14 “(ii) for calendar year 2007, in the  
 15 case of the dollar amount in subsection  
 16 (b)(2)(A)(ii), and

17 “(iii) for calendar year 2003 in the  
 18 case of each dollar amount in subsection  
 19 (c)(2)(A).

20 “(3) GDP FOR ANY CALENDAR YEAR.—For  
 21 purposes of paragraph (2), the GDP for any cal-  
 22 endar year is the average of the chain-weighted price  
 23 index for the gross domestic product as of the close  
 24 of the 12-month period ending on March 31 of such  
 25 calendar year.

1           “(4) CHAIN-WEIGHTED PRICE INDEX FOR THE  
 2           GROSS DOMESTIC PRODUCT.—For purposes of para-  
 3           graph (3), the term ‘chain-weighted price index for  
 4           the gross domestic product’ means the last chain-  
 5           weighted price index for the gross domestic product  
 6           published by the Department of Commerce.

7           “(5) ROUNDING.—Any increase determined  
 8           under paragraph (1) shall be rounded to the nearest  
 9           multiple of \$50.”.

10          (b) USE OF ACCOUNT FOR INDIVIDUAL HIGH DE-  
 11          DUCTIBLE HEALTH PLAN PREMIUMS.—Section  
 12          223(d)(2)(C) of the Internal Revenue Code of 1986 (relat-  
 13          ing to exceptions) is amended by striking “or” at the end  
 14          of clause (iii), by striking the period at the end of clause  
 15          (iv) and inserting “, or”, and by adding at the end the  
 16          following new clause:

17                               “(v) a high deductible health plan, but  
 18                               only if—

19                               “(I) the plan is not a group  
 20                               health plan (as defined in section  
 21                               5000(b)(1) without regard to section  
 22                               5000(d)), and

23                               “(II) the expenses are for cov-  
 24                               erage for a month with respect to  
 25                               which the account beneficiary is an el-

1                   igible individual by reason of the cov-  
2                   erage under the plan.

3           For purposes of clause (v), an arrangement  
4           which constitutes individual health insurance  
5           shall not be treated as a group health plan, not-  
6           withstanding that an employer or employee or-  
7           ganization negotiates the cost of benefits of  
8           such arrangement.”.

9           (c) SAFE HARBOR FOR ABSENCE OF MAINTENANCE  
10       OF CHRONIC DISEASE.—Section 223(c)(2)(C) of the In-  
11       ternal Revenue Code of 1986 (safe harbor for absence of  
12       preventive care deductible) is amended—

13               (1) by inserting “or maintenance of chronic dis-  
14       ease, or both” after “the Secretary”, and

15               (2) by inserting “OR MAINTENANCE OF CHRON-  
16       IC DISEASE” in the heading after “PREVENTIVE  
17       CARE”.

18           (d) CLARIFICATION OF TREATMENT OF CAPITATED  
19       PRIMARY CARE PAYMENTS AS AMOUNTS PAID FOR MED-  
20       ICAL CARE.—Section 213(d) of the Internal Revenue Code  
21       of 1986 (relating to definitions) is amended by adding at  
22       the end the following new paragraph:

23               “(12) TREATMENT OF CAPITATED PRIMARY  
24       CARE PAYMENTS.—Capitated primary care payments  
25       shall be treated as amounts paid for medical care.”.

1       (e) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR  
 2 VETERANS OR INDIAN HEALTH BENEFITS.—Section  
 3 223(c)(1) of the Internal Revenue Code of 1986 (defining  
 4 eligible individual) is amended by adding at the end the  
 5 following new subparagraph:

6               “(C) SPECIAL RULE FOR INDIVIDUALS ELI-  
 7 GIBLE FOR VETERANS OR INDIAN HEALTH BEN-  
 8 EFITS.—For purposes of subparagraph (A)(ii),  
 9 an individual shall not be treated as covered  
 10 under a health plan described in such subpara-  
 11 graph merely because the individual receives  
 12 periodic hospital care or medical services under  
 13 any law administered by the Secretary of Vet-  
 14 erans Affairs or the Bureau of Indian Affairs.”.

15       (f) EFFECTIVE DATES.—

16               (1) IN GENERAL.—Except as provided in para-  
 17 graph (2), the amendments made by this section  
 18 shall apply to taxable years beginning after Decem-  
 19 ber 31, 2007.

20               (2) CAPITATED PRIMARY CARE PAYMENTS.—  
 21 The amendment made by subsection (d) shall apply  
 22 to amounts paid before, on, or after the date of the  
 23 enactment of this Act.

1 **SEC. 202. EXCEPTION TO REQUIREMENT FOR EMPLOYERS**  
 2 **TO MAKE COMPARABLE HEALTH SAVINGS AC-**  
 3 **COUNT CONTRIBUTIONS.**

4 (a) GREATER EMPLOYER-PROVIDED CONTRIBU-  
 5 TIONS TO HSAS FOR CHRONICALLY ILL EMPLOYEES  
 6 TREATED AS MEETING COMPARABILITY REQUIRE-  
 7 MENTS.—Subsection (b) of section 4980G of the Internal  
 8 Revenue Code of 1986 (relating to failure of employer to  
 9 make comparable health savings account contributions) is  
 10 amended to read as follows:

11 “(b) RULES AND REQUIREMENTS.—

12 “(1) IN GENERAL.—Except as provided in para-  
 13 graph (2), rules and requirements similar to the  
 14 rules and requirements of section 4980E shall apply  
 15 for purposes of this section.

16 “(2) TREATMENT OF EMPLOYER-PROVIDED  
 17 CONTRIBUTIONS TO HSAS FOR CHRONICALLY ILL  
 18 EMPLOYEES.—For purposes of this section—

19 “(A) IN GENERAL.—Any contribution by  
 20 an employer to a health savings account of an  
 21 employee who is (or the spouse or any depend-  
 22 ent of the employee who is) a chronically ill in-  
 23 dividual in an amount which is greater than a  
 24 contribution to a health savings account of a  
 25 comparable participating employee who is not a

1 chronically ill individual shall not fail to be con-  
 2 sidered a comparable contribution.

3 “(B) NONDISCRIMINATION REQUIRE-  
 4 MENT.—Subparagraph (A) shall not apply un-  
 5 less the excess employer contributions described  
 6 in subparagraph (A) are the same for all chron-  
 7 ically ill individuals who are similarly situated.

8 “(C) CHRONICALLY ILL INDIVIDUAL.—For  
 9 purposes of this paragraph, the term ‘chron-  
 10 ically ill individual’ means any individual whose  
 11 qualified medical expenses for any taxable year  
 12 are more than 50 percent greater than the av-  
 13 erage qualified medical expenses of all employ-  
 14 ees of the employer for such year.”.

15 (b) EFFECTIVE DATE.—The amendment made by  
 16 this section shall apply to taxable years beginning after  
 17 December 31, 2007.

## 18 **Subtitle B—MediChoice Tax**

### 19 **Rebates**

#### 20 **SEC. 211. REFUNDABLE CREDIT FOR HEALTH INSURANCE**

#### 21 **COVERAGE.**

22 (a) IN GENERAL.—Subpart C of part IV of sub-  
 23 chapter A of chapter 1 of the Internal Revenue Code of  
 24 1986 (relating to refundable credits) is amended by redес-



1 ignating section 36 as section 37 and by inserting after  
 2 section 35 the following new section:

3 **“SEC. 36. MEDICHOICE TAX REBATES.**

4       “(a) IN GENERAL.—In the case of an individual,  
 5 there shall be allowed as a credit against the tax imposed  
 6 by this subtitle an amount equal to the amount paid dur-  
 7 ing the taxable year for qualified health insurance for the  
 8 taxpayer and the taxpayer’s spouse or dependent.

9       “(b) LIMITATIONS.—

10           “(1) IN GENERAL.—The amount allowed as a  
 11 credit under subsection (a) to the taxpayer for the  
 12 taxable year shall not exceed the sum of the monthly  
 13 limitations for coverage months during such taxable  
 14 year for the individual referred to in subsection (a)  
 15 for whom the taxpayer paid during the taxable year  
 16 any amount for coverage under qualified health in-  
 17 surance.

18           “(2) MONTHLY LIMITATION.—

19           “(A) IN GENERAL.—The monthly limita-  
 20 tion for an individual for each coverage month  
 21 of such individual during the taxable year is the  
 22 amount equal to  $\frac{1}{12}$  of the qualified health in-  
 23 surance amount.

1           “(B) QUALIFIED HEALTH INSURANCE  
2 AMOUNT.—For purposes of this paragraph, the  
3 qualified health insurance amount is—

4           “(i) \$2,000 if such individual is the  
5 taxpayer,

6           “(ii) \$2,000 if such individual is the  
7 spouse of the taxpayer, the taxpayer and  
8 such spouse are married as of the first day  
9 of such month, and the taxpayer files a  
10 joint return for the taxable year, or

11           “(iii) \$500 if such individual is an in-  
12 dividual for whom a deduction under sec-  
13 tion 151(c) is allowable to the taxpayer for  
14 such taxable year.

15           “(C) LIMITATION ON DEPENDENTS.—Not  
16 more than 2 individuals may be taken into ac-  
17 count by the taxpayer under subparagraph  
18 (B)(iii).

19           “(3) COVERAGE MONTH.—For purposes of this  
20 subsection—

21           “(A) IN GENERAL.—The term ‘coverage  
22 month’ means, with respect to an individual,  
23 any month if—

1 “(i) as of the first day of such month  
2 such individual is covered by qualified  
3 health insurance, and

4 “(ii) the premium for coverage under  
5 such insurance for such month is paid by  
6 the taxpayer.

7 “(B) MEDICARE.—Such term shall not in-  
8 clude any month with respect to an individual  
9 if, as of the first day of such month, such indi-  
10 vidual has not made an election to establish and  
11 maintain a Medical Retirement Account under  
12 section 252(a)(2) of the Social Security Act and  
13 is entitled to benefits under title XVIII of the  
14 Social Security Act.

15 “(C) CERTAIN OTHER COVERAGE.—Such  
16 term shall not include any month during a tax-  
17 able year with respect to an individual if, at any  
18 time during such year, any benefit is provided  
19 to such individual under—

20 “(i) chapter 55 of title 10, United  
21 States Code,

22 “(ii) chapter 17 of title 38, United  
23 States Code, or

24 “(iii) any medical care program under  
25 the Indian Health Care Improvement Act.

1           “(D) PRISONERS.—Such term shall not in-  
 2           clude any month with respect to an individual  
 3           if, as of the first day of such month, such indi-  
 4           vidual is imprisoned under Federal, State, or  
 5           local authority.

6           “(E) INSUFFICIENT PRESENCE IN UNITED  
 7           STATES.—Such term shall not include any  
 8           month during a taxable year with respect to an  
 9           individual if such individual is present in the  
 10          United States on fewer than 183 days during  
 11          such year (determined in accordance with sec-  
 12          tion 7701(b)(7)).

13          “(c) QUALIFIED HEALTH INSURANCE.—For pur-  
 14          poses of this section—

15               “(1) IN GENERAL.—The term ‘qualified health  
 16               insurance’ means any health plan (within the mean-  
 17               ing of section 223(c)(2)) determined without regard  
 18               to any annual deductible requirement.

19               “(2) ANNUAL WELLNESS EXAM.—Such term  
 20               shall include an annual wellness exam fee not to ex-  
 21               ceed \$150 (\$100 in the case of an annual child  
 22               wellness exam) if such exam is not covered by the  
 23               insurance.

24          “(d) ARCHER MSA AND HEALTH SAVINGS ACCOUNT  
 25          CONTRIBUTIONS.—

1           “(1) IN GENERAL.—If a deduction would (but  
 2           for paragraph (2)) be allowed under section 220 or  
 3           223 to the taxpayer for a payment for the taxable  
 4           year to the Archer MSA or health savings account  
 5           of an individual, subsection (a) shall be applied by  
 6           treating such payment as a payment for qualified  
 7           health insurance for such individual.

8           “(2) DENIAL OF DOUBLE BENEFIT.—No deduc-  
 9           tion shall be allowed under section 220 or 223 for  
 10          that portion of the payments otherwise allowable as  
 11          a deduction under section 220 or 223 for the taxable  
 12          year which is equal to the amount of credit allowed  
 13          for such taxable year by reason of this subsection.

14          “(e) SPECIAL RULES.—For purposes of this sec-  
 15          tion—

16               “(1) MARRIED COUPLES MUST FILE JOINT RE-  
 17               TURN.—If the taxpayer is married at the close of  
 18               the taxable year, the credit shall be allowed under  
 19               subsection (a) only if the taxpayer and the tax-  
 20               payer’s spouse file a joint return for the taxable  
 21               year.

22               “(2) DENIAL OF CREDIT TO DEPENDENTS.—No  
 23               credit shall be allowed under this section to any indi-  
 24               vidual with respect to whom a deduction under sec-  
 25               tion 151 is allowable to another taxpayer for a tax-

1       able year beginning in the calendar year in which  
2       such individual's taxable year begins.

3               “(3) DENIAL OF DOUBLE BENEFIT.—No credit  
4       shall be allowed under subsection (a) if the credit  
5       under section 35 is allowed and no credit shall be al-  
6       lowed under 35 if a credit is allowed under this sec-  
7       tion.

8               “(4) COORDINATION WITH DEDUCTION FOR  
9       HEALTH INSURANCE COSTS.—In the case of a tax-  
10      payer who is eligible to deduct any amount under  
11      section 162(l) or 213 for the taxable year, this sec-  
12      tion shall apply only if the taxpayer elects not to  
13      claim any amount as a deduction under such section  
14      for such year.

15              “(5) ELECTION NOT TO CLAIM CREDIT.—This  
16      section shall not apply to a taxpayer for any taxable  
17      year if such taxpayer elects to have this section not  
18      apply for such taxable year.

19              “(6) INFLATION ADJUSTMENT.—

20                      “(A) IN GENERAL.—In the case of any  
21                      taxable year beginning in a calendar year after  
22                      2008, each dollar amount contained in sub-  
23                      section (b)(2)(B) shall be increased by an  
24                      amount equal to—

25                              “(i) such dollar amount, multiplied by

1                   “(ii) the cost-of-living adjustment de-  
2                   termined under subparagraph (B) for the  
3                   calendar year in which such taxable year  
4                   begins.

5                   “(B) COST-OF-LIVING ADJUSTMENT.—For  
6                   purposes of subparagraph (A), the cost-of-living  
7                   adjustment for any calendar year is the per-  
8                   centage (if any) by which—

9                   “(i) the GDP for the preceding cal-  
10                  endar year, exceeds

11                  “(ii) the GDP for calendar year 2007.

12                  “(C) GDP FOR ANY CALENDAR YEAR.—  
13                  For purposes of subparagraph (B), the GDP  
14                  for any calendar year is the average of the  
15                  chain-weighted price index for the gross domes-  
16                  tic product as of the close of the 12-month pe-  
17                  riod ending on March 31 of such calendar year.

18                  “(D) CHAIN-WEIGHTED PRICE INDEX FOR  
19                  THE GROSS DOMESTIC PRODUCT.—For pur-  
20                  poses of subparagraph (C), the term ‘chain-  
21                  weighted price index for the gross domestic  
22                  product’ means the last chain-weighted price  
23                  index for the gross domestic product published  
24                  by the Department of Commerce.

1           “(E) ROUNDING.—Any increase deter-  
 2           mined under subparagraph (A) shall be rounded  
 3           to the nearest multiple of \$50.”.

4           (b) INFORMATION REPORTING.—

5           (1) IN GENERAL.—Subpart B of part III of  
 6           subchapter A of chapter 61 of the Internal Revenue  
 7           Code of 1986 (relating to information concerning  
 8           transactions with other persons) is amended by in-  
 9           serting after section 6050V the following new sec-  
 10          tion:

11       **“SEC. 6050W. RETURNS RELATING TO PAYMENTS FOR**  
 12               **QUALIFIED HEALTH INSURANCE.**

13          “(a) IN GENERAL.—Any person who, in connection  
 14       with a trade or business conducted by such person, re-  
 15       ceives payments during any calendar year from any indi-  
 16       vidual for coverage of such individual or any other indi-  
 17       vidual under creditable health insurance, shall make the  
 18       return described in subsection (b) (at such time as the  
 19       Secretary may by regulations prescribe) with respect to  
 20       each individual from whom such payments were received.

21          “(b) FORM AND MANNER OF RETURNS.—A return  
 22       is described in this subsection if such return—

23               “(1) is in such form as the Secretary may pre-  
 24               scribe, and

25               “(2) contains—



1           “(A) the name, address, and TIN of the  
2           individual from whom payments described in  
3           subsection (a) were received,

4           “(B) the name, address, and TIN of each  
5           individual who was provided by such person  
6           with coverage under creditable health insurance  
7           by reason of such payments and the period of  
8           such coverage, and

9           “(C) such other information as the Sec-  
10          retary may reasonably prescribe.

11       “(c) CREDITABLE HEALTH INSURANCE.—For pur-  
12       poses of this section, the term ‘creditable health insurance’  
13       means qualified health insurance (as defined in section  
14       36(c)) other than, to the extent provided in regulations  
15       prescribed by the Secretary, any insurance covering an in-  
16       dividual if no credit is allowable under section 36 with re-  
17       spect to such coverage.

18       “(d) STATEMENTS TO BE FURNISHED TO INDIVID-  
19       UALS WITH RESPECT TO WHOM INFORMATION IS RE-  
20       QUIRED.—Every person required to make a return under  
21       subsection (a) shall furnish to each individual whose name  
22       is required under subsection (b)(2)(A) to be set forth in  
23       such return a written statement showing—

1           “(1) the name and address of the person re-  
 2           quired to make such return and the phone number  
 3           of the information contact for such person,

4           “(2) the aggregate amount of payments de-  
 5           scribed in subsection (a) received by the person re-  
 6           quired to make such return from the individual to  
 7           whom the statement is required to be furnished, and

8           “(3) the information required under subsection  
 9           (b)(2)(B) with respect to such payments.

10 The written statement required under the preceding sen-  
 11 tence shall be furnished on or before January 31 of the  
 12 year following the calendar year for which the return  
 13 under subsection (a) is required to be made.

14           “(e) RETURNS WHICH WOULD BE REQUIRED TO BE  
 15 MADE BY 2 OR MORE PERSONS.—Except to the extent  
 16 provided in regulations prescribed by the Secretary, in the  
 17 case of any amount received by any person on behalf of  
 18 another person, only the person first receiving such  
 19 amount shall be required to make the return under sub-  
 20 section (a).”.

21           (2) ASSESSABLE PENALTIES.—

22                   (A) Subparagraph (B) of section  
 23           6724(d)(1) of such Code (relating to defini-  
 24           tions) is amended by redesignating clauses (xv)  
 25           through (xx) as clauses (xvi) through (xxi), re-

1           spectively, and by inserting after clause (xi) the  
2           following new clause:

3                   “(xv) section 6050W (relating to re-  
4                   turns relating to payments for qualified  
5                   health insurance),”.

6           (B) Paragraph (2) of section 6724(d) of  
7           such Code is amended by striking the period at  
8           the end of subparagraph (CC) and inserting “,  
9           or” and by adding at the end the following new  
10          subparagraph:

11                   “(DD) section 6050W(d) (relating to re-  
12                   turns relating to payments for qualified health  
13                   insurance).”.

14          (3) CLERICAL AMENDMENT.—The table of sec-  
15          tions for subpart B of part III of subchapter A of  
16          chapter 61 of such Code is amended by inserting  
17          after the item relating to section 6050V the fol-  
18          lowing new item:

“Sec. 6050W. Returns relating to payments for qualified health insurance.”.

19          (c) CONFORMING AMENDMENTS.—

20                   (1) Paragraph (2) of section 1324(b) of title  
21                   31, United States Code, is amended by inserting be-  
22                   fore the period “, or from section 36 of such Code”.

23                   (2) The table of sections for subpart C of part  
24                   IV of subchapter A of chapter 1 of the Internal Rev-

1        enue Code of 1986 is amended by striking the last  
 2        item and inserting the following new items:

“Sec. 36. MediChoice tax rebates.  
 “Sec. 37. Overpayments of tax.”.

3        (d) **EFFECTIVE DATE.**—The amendments made by  
 4 this section shall apply to taxable years beginning after  
 5 December 31, 2007.

6 **SEC. 212. ADVANCE PAYMENT OF CREDIT FOR PUR-**  
 7 **CHASERS OF QUALIFIED HEALTH INSUR-**  
 8 **ANCE.**

9        (a) **IN GENERAL.**—Chapter 77 of the Internal Rev-  
 10 enue Code of 1986 (relating to miscellaneous provisions)  
 11 is amended by adding at the end the following new section:  
 12 **“SEC. 7529. ADVANCE PAYMENT OF MEDICHOICE TAX RE-**  
 13 **BATES.**

14        “(a) **GENERAL RULE.**—In the case of an eligible indi-  
 15 vidual, the Secretary shall make payments to the provider  
 16 of such individual’s qualified health insurance equal to  
 17 such individual’s qualified health insurance credit advance  
 18 amount with respect to such provider.

19        “(b) **ELIGIBLE INDIVIDUAL.**—For purposes of this  
 20 section, the term ‘eligible individual’ means any indi-  
 21 vidual—

22                “(1) who purchases qualified health insurance  
 23                (as defined in section 36(c)), and

1           “(2) for whom a qualified health insurance  
2           credit eligibility certificate is in effect.

3           “(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGI-  
4           BILITY CERTIFICATE.—For purposes of this section, a  
5           qualified health insurance credit eligibility certificate is a  
6           statement furnished by an individual to the Secretary  
7           which—

8           “(1) certifies that the individual will be eligible  
9           to receive the credit provided by section 36 for the  
10          taxable year,

11          “(2) estimates the amount of such credit for  
12          such taxable year, and

13          “(3) provides such other information as the  
14          Secretary may require for purposes of this section.

15          “(d) QUALIFIED HEALTH INSURANCE CREDIT AD-  
16          VANCE AMOUNT.—For purposes of this section, the term  
17          ‘qualified health insurance credit advance amount’ means,  
18          with respect to any provider of qualified health insurance,  
19          the Secretary’s estimate of the amount of credit allowable  
20          under section 36 to the individual for the taxable year  
21          which is attributable to the insurance provided to the indi-  
22          vidual by such provider.

23          “(e) REGULATIONS.—The Secretary shall prescribe  
24          such regulations as may be necessary to carry out the pur-  
25          poses of this section.”.

1 (b) CLERICAL AMENDMENT.—The table of sections  
 2 for chapter 77 of the Internal Revenue Code of 1986 is  
 3 amended by adding at the end the following new item:

“Sec. 7529. Advance payment of MediChoice tax rebates.”.

4 (c) EFFECTIVE DATE.—The amendments made by  
 5 this section shall apply to taxable years beginning after  
 6 December 31, 2007.

7 **SEC. 213. TERMINATION OF EMPLOYER-PROVIDED HEALTH**  
 8 **CARE COVERAGE EXCLUSION.**

9 (a) IN GENERAL.—Section 106 of the Internal Rev-  
 10 enue Code of 1986 (relating to contributions by employer  
 11 to accident and health plans) is amended by adding at the  
 12 end the following new subsection:

13 “(e) TERMINATION OF EMPLOYER-PROVIDED  
 14 HEALTH CARE COVERAGE EXCLUSION.—

15 “(1) IN GENERAL.—The amount of any exclu-  
 16 sion under subsection (a) for any taxable year begin-  
 17 ning after December 31, 2007, with respect to—

18 “(A) any employer-provided coverage  
 19 under an accident or health plan which con-  
 20 stitutes medical care, and

21 “(B) any employer contribution to an Ar-  
 22 cher MSA or a health savings account which is  
 23 treated by subsection (b) or (d) as employer-  
 24 provided coverage for medical expenses under  
 25 an accident or health plan,

1       shall be zero.

2               “(2) MEDICAL CARE DEFINED.—For purposes  
3       of paragraph (1), the term ‘medical care’ has the  
4       meaning given to such term in section 213(d) deter-  
5       mined without regard to—

6               “(A) paragraph (1)(C) thereof, and

7               “(B) so much of paragraph (1)(D) thereof  
8       as relates to qualified long-term care insur-  
9       ance.”.

10       (b) TERMINATION OF HEALTH CARE EXPENSE RE-  
11       IMBURSEMENT UNDER CAFETERIA PLANS.—Section 125  
12       of the Internal Revenue Code of 1986 (relating to cafe-  
13       teria plans) is amended by redesignating subsection (h)  
14       as subsection (i) and by inserting after subsection (g) the  
15       following new subsection:

16       “(h) TERMINATION.—This section shall not apply to  
17       health benefits coverage in any taxable year beginning  
18       after December 31, 2007.”.

19       (c) TERMINATION OF DEDUCTION FOR HEALTH IN-  
20       SURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—  
21       The table contained in section 162(l)(1)(B) of the Internal  
22       Revenue Code of 1986 (relating to applicable percentage)  
23       is amended by striking “and thereafter” and inserting  
24       “through 2007”.

25       (d) PAYROLL TAXES.—

1           (1) IN GENERAL.—Section 3121(a) of the In-  
 2           ternal Revenue Code of 1986 (defining wages) is  
 3           amended by adding at the end the following new  
 4           sentence: “In the case of any calendar year begin-  
 5           ning after December 31, 2007, paragraphs (2) and  
 6           (4) shall not apply to payments on account of sick-  
 7           ness.”.

8           (2)       RAILROAD       RETIREMENT.—Section  
 9           3231(e)(1) of such Code (defining wages) is amend-  
 10          ed by adding at the end the following new sentence:  
 11          “In the case of any calendar year beginning after  
 12          December 31, 2007, this paragraph shall not apply  
 13          to payments on account of sickness.”.

14          (3) UNEMPLOYMENT.—Section 3306(b) of such  
 15          Code (defining wages) is amended by adding at the  
 16          end the following new sentence: “In the case of any  
 17          calendar year beginning after December 31, 2007,  
 18          paragraphs (2) and (4) shall not apply to payments  
 19          on account of sickness.”.

20          (e) EFFECTIVE DATES.—

21               (1) IN GENERAL.—Except as provided in para-  
 22               graph (2), the amendments made by this section  
 23               shall apply to taxable years beginning after Decem-  
 24               ber 31, 2007.



1           (2) PAYROLL TAXES.—The amendments made  
 2       by subsection (d) shall apply to calendar years be-  
 3       ginning after December 31, 2007.

4       **TITLE III—HEALTH INSURANCE**  
 5               **MODERNIZATION**

6           **Subtitle A—Employee Choice**

7       **SEC. 301. CLARIFICATION OF DEFINITION OF GROUP**  
 8               **HEALTH PLAN UNDER HIPAA.**

9           (a) ERISA.—Section 733(a)(1) of the Employee Re-  
 10      tirement Income Security Act of 1974 (29 U.S.C.  
 11      1191b(a)(1)) is amended by adding at the end the fol-  
 12      lowing: “Such term does not include an arrangement  
 13      maintained by an employer the sole effect of which is to  
 14      provide reimbursement to employees for the purchase by  
 15      such employees of health insurance coverage offered in the  
 16      individual market (as defined in section 2791(e)(1)) of the  
 17      Public Health Service Act), notwithstanding that the em-  
 18      ployer or an employee organization negotiates the cost or  
 19      benefits of the arrangement.”.

20          (b) PHSA.—Section 2791(a)(1) of the Public Health  
 21      Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by  
 22      adding at the end the following: “Such term does not in-  
 23      clude an arrangement maintained by an employer the sole  
 24      effect of which is to provide reimbursement to employees  
 25      for the purchase by such employees of health insurance

1 coverage offered in the individual market, notwithstanding  
 2 that the employer or an employee organization negotiates  
 3 the cost or benefits of the arrangement.”.

4 (c) IRC.—Section 9832(a) of the Internal Revenue  
 5 Code of 1986 (relating to definitions) is amended by in-  
 6 serting before the period the following: “, except that such  
 7 term does not include an arrangement maintained by an  
 8 employer the sole effect of which is to provide reimburse-  
 9 ment to employees for the purchase by such employees of  
 10 health insurance coverage offered in the individual market  
 11 (as defined in section 2791(e)(1)) of the Public Health  
 12 Service Act), notwithstanding that the employer or an em-  
 13 ployee organization negotiates the cost or benefits of the  
 14 arrangement.”.

15 (d) EFFECTIVE DATE.—The amendments made by  
 16 this section shall apply to plan years beginning after De-  
 17 cember 31, 2007.

## 18 **Subtitle B—Access to Health Care**

### 19 **SEC. 311. STATE HIGH RISK POOLS.**

20 (a) IN GENERAL.—Not later than 1 year after the  
 21 date of enactment of this Act, each State shall have estab-  
 22 lished, and be operating, a qualified high risk pool (as de-  
 23 fined for purposes of section 2745 of the Public Health  
 24 Service Act (42 U.S.C. 300gg–45)) or a State-designated

1 alternative that ensures access to private health insurance  
2 for medically uninsurable individuals.

3 (b) BONUS FOR COMPLIANCE.—

4 (1) ONE-TIME PAYMENT.—If the Secretary of  
5 Health and Human Services determines that a State  
6 has satisfied the requirement of subsection (a) with  
7 respect to a fiscal year, the Secretary shall increase  
8 the total amount of Federal payments made to the  
9 State under section 1903(a) of the Social Security  
10 Act (42 U.S.C. 1396b(a)) for the succeeding fiscal  
11 year by an amount equal to 1 percent of such pay-  
12 ments (or, if such succeeding fiscal year is fiscal  
13 year 2010 or any fiscal year thereafter, by an  
14 amount equal to 1 percent of the State Medicaid as-  
15 sistance allotment determined for the State for such  
16 succeeding fiscal year under section 1939(b) of such  
17 Act). The additional amount paid to a State for a  
18 fiscal year pursuant to this paragraph shall be used  
19 for maintenance and operational costs of a qualified  
20 high risk pool (as so defined) or a State-designated  
21 alternative that ensures access to private health in-  
22 surance for medically uninsurable individuals.

23 (2) AUTHORIZATION OF APPROPRIATIONS.—

24 There are authorized to be appropriated for any fis-

1 cal year such sums as may be necessary to carry out  
 2 this subsection.

3 **SEC. 312. FEDERALLY QUALIFIED HEALTH CENTERS.**

4 (a) EVALUATION.—Not later than 5 years after the  
 5 date of enactment of this Act, and every 5 years there-  
 6 after, the Secretary of Health and Human Services shall  
 7 evaluate the effect of federally qualified health centers on  
 8 proximate rural hospitals.

9 (b) LIMITATION ON GRANTS.—Notwithstanding any  
 10 other provision of law, if the Secretary of Health and  
 11 Human Services determines, based on an evaluation con-  
 12 ducted under subsection (a), that a federally qualified  
 13 health center is having a detrimental effect on a private  
 14 hospital facility, the Secretary may revoke a grant award-  
 15 ed by the Secretary to such health center or limit the scope  
 16 of services of the health center under such a grant.

17 **Subtitle C—Interstate Market for**  
 18 **Health Insurance**

19 **SEC. 321. SHORT TITLE.**

20 This subtitle may be cited as “Health Care Choice  
 21 Act of 2007”.

1 **SEC. 322. SPECIFICATION OF CONSTITUTIONAL AUTHORITY**  
2 **FOR ENACTMENT OF LAW.**

3 This subtitle is enacted pursuant to the power grant-  
4 ed Congress under article I, section 8, clause 3, of the  
5 United States Constitution.

6 **SEC. 323. FINDINGS.**

7 Congress finds the following:

8 (1) The application of numerous and significant  
9 variations in State law impacts the ability of insur-  
10 ers to offer, and individuals to obtain, affordable in-  
11 dividual health insurance coverage, thereby impeding  
12 commerce in individual health insurance coverage.

13 (2) Individual health insurance coverage is in-  
14 creasingly offered through the Internet, other elec-  
15 tronic means, and by mail, all of which are inher-  
16 ently part of interstate commerce.

17 (3) In response to these issues, it is appropriate  
18 to encourage increased efficiency in the offering of  
19 individual health insurance coverage through a col-  
20 laborative approach by the States in regulating this  
21 coverage.

22 (4) The establishment of risk-retention groups  
23 has provided a successful model for the sale of insur-  
24 ance across State lines, as the acts establishing  
25 those groups allow insurance to be sold in multiple  
26 States but regulated by a single State.

1 **SEC. 324. COOPERATIVE GOVERNING OF INDIVIDUAL**  
 2 **HEALTH INSURANCE COVERAGE.**

3 (a) IN GENERAL.—Title XXVII of the Public Health  
 4 Service Act (42 U.S.C. 300gg et seq.) is amended by add-  
 5 ing at the end the following new part:

6 **“PART D—COOPERATIVE GOVERNING OF**  
 7 **INDIVIDUAL HEALTH INSURANCE COVERAGE**

8 **“SEC. 2795. DEFINITIONS.**

9 “In this part:

10 “(1) PRIMARY STATE.—The term ‘primary  
 11 State’ means, with respect to individual health insur-  
 12 ance coverage offered by a health insurance issuer,  
 13 the State designated by the issuer as the State  
 14 whose covered laws shall govern the health insurance  
 15 issuer in the sale of such coverage under this part.  
 16 An issuer, with respect to a particular policy, may  
 17 only designate 1 such State as its primary State  
 18 with respect to all such coverage it offers. Such an  
 19 issuer may not change the designated primary State  
 20 with respect to individual health insurance coverage  
 21 once the policy is issued, except that such a change  
 22 may be made upon renewal of the policy. With re-  
 23 spect to such designated State, the issuer is deemed  
 24 to be doing business in that State.

25 “(2) SECONDARY STATE.—The term ‘secondary  
 26 State’ means, with respect to individual health insur-

1       ance coverage offered by a health insurance issuer,  
 2       any State that is not the primary State. In the case  
 3       of a health insurance issuer that is selling a policy  
 4       in, or to a resident of, a secondary State, the issuer  
 5       is deemed to be doing business in that secondary  
 6       State.

7               “(3) HEALTH INSURANCE ISSUER.—The term  
 8       ‘health insurance issuer’ has the meaning given such  
 9       term in section 2791(b)(2), except that such an  
 10       issuer must be licensed in the primary State and be  
 11       qualified to sell individual health insurance coverage  
 12       in that State.

13              “(4) INDIVIDUAL HEALTH INSURANCE COV-  
 14       ERAGE.—The term ‘individual health insurance cov-  
 15       erage’ means health insurance coverage offered in  
 16       the individual market, as defined in section  
 17       2791(e)(1).

18              “(5) APPLICABLE STATE AUTHORITY.—The  
 19       term ‘applicable State authority’ means, with respect  
 20       to a health insurance issuer in a State, the State in-  
 21       surance commissioner or official or officials des-  
 22       ignated by the State to enforce the requirements of  
 23       this title for the State with respect to the issuer.

24              “(6) HAZARDOUS FINANCIAL CONDITION.—The  
 25       term ‘hazardous financial condition’ means that,

1 based on its present or reasonably anticipated finan-  
 2 cial condition, a health insurance issuer is unlikely  
 3 to be able—

4 “(A) to meet obligations to policyholders  
 5 with respect to known claims and reasonably  
 6 anticipated claims; or

7 “(B) to pay other obligations in the normal  
 8 course of business.

9 “(7) COVERED LAWS.—The term ‘covered laws’  
 10 means the laws, rules, regulations, agreements, and  
 11 orders governing the insurance business pertaining  
 12 to—

13 “(A) individual health insurance coverage  
 14 issued by a health insurance issuer;

15 “(B) the offer, sale, and issuance of indi-  
 16 vidual health insurance coverage to an indi-  
 17 vidual; and

18 “(C) the provision to an individual in rela-  
 19 tion to individual health insurance coverage  
 20 of—

21 “(i) health care and insurance related  
 22 services;

23 “(ii) management, operations, and in-  
 24 vestment activities of a health insurance  
 25 issuer; and



1                   “(iii) loss control and claims adminis-  
2                   tration for a health insurance issuer with  
3                   respect to liability for which the issuer pro-  
4                   vides insurance.

5                   “(8) STATE.—The term ‘State’ means only the  
6                   50 States and the District of Columbia.

7                   “(9) UNFAIR CLAIMS SETTLEMENT PRAC-  
8                   TICES.—The term ‘unfair claims settlement prac-  
9                   tices’ means only the following practices:

10                   “(A) Knowingly misrepresenting to claim-  
11                   ants and insured individuals relevant facts or  
12                   policy provisions relating to coverage at issue.

13                   “(B) Failing to acknowledge with reason-  
14                   able promptness pertinent communications with  
15                   respect to claims arising under policies.

16                   “(C) Failing to adopt and implement rea-  
17                   sonable standards for the prompt investigation  
18                   and settlement of claims arising under policies.

19                   “(D) Failing to effectuate prompt, fair,  
20                   and equitable settlement of claims submitted in  
21                   which liability has become reasonably clear.

22                   “(E) Refusing to pay claims without con-  
23                   ducting a reasonable investigation.

24                   “(F) Failing to affirm or deny coverage of  
25                   claims within a reasonable period of time after

1           having completed an investigation related to  
2           those claims.

3           “(10) FRAUD AND ABUSE.—The term ‘fraud  
4           and abuse’ means an act or omission committed by  
5           a person who, knowingly and with intent to defraud,  
6           commits, or conceals any material information con-  
7           cerning, 1 or more of the following:

8                   “(A) Presenting, causing to be presented  
9                   or preparing with knowledge or belief that it  
10                  will be presented to or by an insurer, a rein-  
11                  surer, broker or its agent, false information as  
12                  part of, in support of or concerning a fact ma-  
13                  terial to 1 or more of the following:

14                           “(i) An application for the issuance or  
15                           renewal of an insurance policy or reinsur-  
16                           ance contract.

17                           “(ii) The rating of an insurance policy  
18                           or reinsurance contract.

19                           “(iii) A claim for payment or benefit  
20                           pursuant to an insurance policy or reinsur-  
21                           ance contract.

22                           “(iv) Premiums paid on an insurance  
23                           policy or reinsurance contract.

1                   “(v) Payments made in accordance  
2                   with the terms of an insurance policy or  
3                   reinsurance contract.

4                   “(vi) A document filed with the com-  
5                   missioner or the chief insurance regulatory  
6                   official of another jurisdiction.

7                   “(vii) The financial condition of an in-  
8                   surer or reinsurer.

9                   “(viii) The formation, acquisition,  
10                  merger, reconsolidation, dissolution or  
11                  withdrawal from 1 or more lines of insur-  
12                  ance or reinsurance in all or part of a  
13                  State by an insurer or reinsurer.

14                  “(ix) The issuance of written evidence  
15                  of insurance.

16                  “(x) The reinstatement of an insur-  
17                  ance policy.

18                  “(B) Solicitation or acceptance of new or  
19                  renewal insurance risks on behalf of an insurer  
20                  reinsurer or other person engaged in the busi-  
21                  ness of insurance by a person who knows or  
22                  should know that the insurer or other person  
23                  responsible for the risk is insolvent at the time  
24                  of the transaction.

1           “(C) Transaction of the business of insur-  
2           ance in violation of laws requiring a license, cer-  
3           tificate of authority, or other legal authority for  
4           the transaction of the business of insurance.

5           “(D) Attempt to commit, aiding or abet-  
6           ting in the commission of, or conspiracy to com-  
7           mit the acts or omissions specified in this para-  
8           graph.

9   **“SEC. 2796. APPLICATION OF LAW.**

10       “(a) IN GENERAL.—The covered laws of the primary  
11   State shall apply to individual health insurance coverage  
12   offered by a health insurance issuer in the primary State  
13   and in any secondary State, but only if the coverage and  
14   issuer comply with the conditions of this section with re-  
15   spect to the offering of coverage in any secondary State.

16       “(b) EXEMPTIONS FROM COVERED LAWS IN A SEC-  
17   ONDARY STATE.—Except as provided in this section, a  
18   health insurance issuer with respect to its offer, sale, re-  
19   newal, and issuance of individual health insurance cov-  
20   erage in any secondary State is exempt from any covered  
21   laws of the secondary State (and any rules, regulations,  
22   agreements, or orders sought or issued by such State  
23   under or related to such covered laws) to the extent that  
24   such laws would—

1           “(1) make unlawful, or regulate, directly or in-  
2           directly, the operation of the health insurance issuer  
3           operating in the secondary State, except that any  
4           secondary State may require such an issuer—

5                   “(A) to pay, on a nondiscriminatory basis,  
6           applicable premium and other taxes (including  
7           high risk pool assessments) which are levied on  
8           insurers and surplus lines insurers, brokers, or  
9           policyholders under the laws of the State;

10                   “(B) to register with and designate the  
11           State insurance commissioner as its agent solely  
12           for the purpose of receiving service of legal doc-  
13           uments or process;

14                   “(C) to submit to an examination of its fi-  
15           nancial condition by the State insurance com-  
16           missioner in any State in which the issuer is  
17           doing business to determine the issuer’s finan-  
18           cial condition, if—

19                           “(i) the State insurance commissioner  
20                   of the primary State has not done an ex-  
21                   amination within the period recommended  
22                   by the National Association of Insurance  
23                   Commissioners; and

24                           “(ii) any such examination is con-  
25                   ducted in accordance with the examiners’

1 handbook of the National Association of  
2 Insurance Commissioners and is coordi-  
3 nated to avoid unjustified duplication and  
4 unjustified repetition;

5 “(D) to comply with a lawful order  
6 issued—

7 “(i) in a delinquency proceeding com-  
8 menced by the State insurance commis-  
9 sioner if there has been a finding of finan-  
10 cial impairment under subparagraph (C);  
11 or

12 “(ii) in a voluntary dissolution pro-  
13 ceeding;

14 “(E) to comply with an injunction issued  
15 by a court of competent jurisdiction, upon a pe-  
16 tition by the State insurance commissioner al-  
17 leging that the issuer is in hazardous financial  
18 condition;

19 “(F) to participate, on a nondiscriminatory  
20 basis, in any insurance insolvency guaranty as-  
21 sociation or similar association to which a  
22 health insurance issuer in the State is required  
23 to belong;

24 “(G) to comply with any State law regard-  
25 ing fraud and abuse (as defined in section

1           2795(10)), except that if the State seeks an in-  
2           junction regarding the conduct described in this  
3           subparagraph, such injunction must be obtained  
4           from a court of competent jurisdiction; or

5           “(H) to comply with any State law regard-  
6           ing unfair claims settlement practices (as de-  
7           fined in section 2795(9));

8           “(2) require any individual health insurance  
9           coverage issued by the issuer to be countersigned by  
10          an insurance agent or broker residing in that Sec-  
11          ondary State; or

12          “(3) otherwise discriminate against the issuer  
13          issuing insurance in both the primary State and in  
14          any secondary State.

15          “(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A  
16          health insurance issuer shall provide the following notice,  
17          in 12-point bold type, in any insurance coverage offered  
18          in a secondary State under this part by such a health in-  
19          surance issuer and at renewal of the policy, with the 5  
20          blank spaces therein being appropriately filled with the  
21          name of the health insurance issuer, the name of the pri-  
22          mary State, and the name of the secondary State, respec-  
23          tively, for the coverage concerned:

24          ‘This policy is issued by \_\_\_\_\_ and is governed by  
25          the laws and regulations of the State of \_\_\_\_\_, and

1 it has met all the laws of that State as determined by  
 2 that State’s Department of Insurance. This policy may be  
 3 less expensive than others because it is not subject to all  
 4 of the insurance laws and regulations of the State of  
 5 \_\_\_\_\_, including coverage of some services or bene-  
 6 fits mandated by the law of the State of \_\_\_\_\_. Ad-  
 7 ditionally, this policy is not subject to all of the consumer  
 8 protection laws or restrictions on rate changes of the State  
 9 of \_\_\_\_\_. As with all insurance products, before pur-  
 10 chasing this policy, you should carefully review the policy  
 11 and determine what health care services the policy covers  
 12 and what benefits it provides, including any exclusions,  
 13 limitations, or conditions for such services or benefits.’.

14 “(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS  
 15 AND PREMIUM INCREASES.—

16 “(1) IN GENERAL.—For purposes of this sec-  
 17 tion, a health insurance issuer that provides indi-  
 18 vidual health insurance coverage to an individual  
 19 under this part in a primary or secondary State may  
 20 not upon renewal—

21 “(A) move or reclassify the individual in-  
 22 sured under the health insurance coverage from  
 23 the class such individual is in at the time of  
 24 issue of the contract based on the health-status  
 25 related factors of the individual; or



1           “(B) increase the premiums assessed the  
 2           individual for such coverage based on a health-  
 3           status related factor or change of a health-sta-  
 4           tus related factor or the past or prospective  
 5           claim experience of the insured individual.

6           “(2) CONSTRUCTION.—Nothing in paragraph  
 7           (1) shall be construed to prohibit a health insurance  
 8           issuer—

9           “(A) from terminating or discontinuing  
 10          coverage or a class of coverage in accordance  
 11          with subsections (b) and (c) of section 2742;

12          “(B) from raising premium rates for all  
 13          policyholders within a class based on claims ex-  
 14          perience;

15          “(C) from changing premiums or offering  
 16          discounted premiums to individuals who engage  
 17          in wellness activities at intervals prescribed by  
 18          the issuer, if such premium changes or incen-  
 19          tives—

20                 “(i) are disclosed to the consumer in  
 21                 the insurance contract;

22                 “(ii) are based on specific wellness ac-  
 23                 tivities that are not applicable to all indi-  
 24                 viduals; and

1                   “(iii) are not obtainable by all individ-  
2                   uals to whom coverage is offered;

3                   “(D) from reinstating lapsed coverage; or

4                   “(E) from retroactively adjusting the rates  
5                   charged an individual insured individual if the  
6                   initial rates were set based on material mis-  
7                   representation by the individual at the time of  
8                   issue.

9           “(e) PRIOR OFFERING OF POLICY IN PRIMARY  
10   STATE.—A health insurance issuer may not offer for sale  
11   individual health insurance coverage in a secondary State  
12   unless that coverage is currently offered for sale in the  
13   primary State.

14          “(f) LICENSING OF AGENTS OR BROKERS FOR  
15   HEALTH INSURANCE ISSUERS.—Any State may require  
16   that a person acting, or offering to act, as an agent or  
17   broker for a health insurance issuer with respect to the  
18   offering of individual health insurance coverage obtain a  
19   license from that State, except that a State may not im-  
20   pose any qualification or requirement which discriminates  
21   against a nonresident agent or broker.

22          “(g) DOCUMENTS FOR SUBMISSION TO STATE IN-  
23   SURANCE COMMISSIONER.—Each health insurance issuer  
24   issuing individual health insurance coverage in both pri-  
25   mary and secondary States shall submit—

1           “(1) to the insurance commissioner of each  
 2           State in which it intends to offer such coverage, be-  
 3           fore it may offer individual health insurance cov-  
 4           erage in such State—

5                   “(A) a copy of the plan of operation or fea-  
 6                   sibility study or any similar statement of the  
 7                   policy being offered and its coverage (which  
 8                   shall include the name of its primary State and  
 9                   its principal place of business);

10                   “(B) written notice of any change in its  
 11                   designation of its primary State; and

12                   “(C) written notice from the issuer of the  
 13                   issuer’s compliance with all the laws of the pri-  
 14                   mary State; and

15           “(2) to the insurance commissioner of each sec-  
 16           ondary State in which it offers individual health in-  
 17           surance coverage, a copy of the issuer’s quarterly fi-  
 18           nancial statement submitted to the primary State,  
 19           which statement shall be certified by an independent  
 20           public accountant and contain a statement of opin-  
 21           ion on loss and loss adjustment expense reserves  
 22           made by—

23                   “(A) a member of the American Academy  
 24                   of Actuaries; or

25                   “(B) a qualified loss reserve specialist.

1 “(h) POWER OF COURTS TO ENJOIN CONDUCT.—

2 Nothing in this section shall be construed to affect the  
3 authority of any Federal or State court to enjoin—

4 “(1) the solicitation or sale of individual health  
5 insurance coverage by a health insurance issuer to  
6 any person or group who is not eligible for such in-  
7 surance; or

8 “(2) the solicitation or sale of individual health  
9 insurance coverage by, or operation of, a health in-  
10 surance issuer that is in hazardous financial condi-  
11 tion.

12 “(i) STATE POWERS TO ENFORCE STATE LAWS.—

13 “(1) IN GENERAL.—Subject to the provisions of  
14 subsection (b)(1)(G) (relating to injunctions) and  
15 paragraph (2), nothing in this section shall be con-  
16 strued to affect the authority of any State to make  
17 use of any of its powers to enforce the laws of such  
18 State with respect to which a health insurance issuer  
19 is not exempt under subsection (b).

20 “(2) COURTS OF COMPETENT JURISDICTION.—

21 If a State seeks an injunction regarding the conduct  
22 described in paragraphs (1) and (2) of subsection  
23 (h), such injunction must be obtained from a Fed-  
24 eral or State court of competent jurisdiction.

1       “(j) STATES’ AUTHORITY TO SUE.—Nothing in this  
 2 section shall affect the authority of any State to bring ac-  
 3 tion in any Federal or State court.

4       “(k) GENERALLY APPLICABLE LAWS.—Nothing in  
 5 this section shall be construed to affect the applicability  
 6 of State laws generally applicable to persons or corpora-  
 7 tions.

8       **“SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR**  
 9                               **BEFORE ISSUER MAY SELL INTO SECONDARY**  
 10                              **STATES.**

11       “A health insurance issuer may not offer, sell, or  
 12 issue individual health insurance coverage in a secondary  
 13 State if the primary State does not meet the following re-  
 14 quirements:

15               “(1) The State insurance commissioner must  
 16 use a risk-based capital formula for the determina-  
 17 tion of capital and surplus requirements for all  
 18 health insurance issuers.

19               “(2) The State must have legislation or regula-  
 20 tions in place establishing an independent review  
 21 process for individuals who are covered by individual  
 22 health insurance coverage unless the issuer provides  
 23 an independent review mechanism functionally equiv-  
 24 alent (as determined by the primary State insurance  
 25 commissioner or official) to that prescribed in the

1       ‘Health Carrier External Review Model Act’ of the  
2       National Association of Insurance Commissioners for  
3       all individuals who purchase insurance coverage  
4       under the terms of this part.

5   **“SEC. 2798. ENFORCEMENT.**

6       “(a) IN GENERAL.—Subject to subsection (b), with  
7       respect to specific individual health insurance coverage the  
8       primary State for such coverage has sole jurisdiction to  
9       enforce the primary State’s covered laws in the primary  
10      State and any secondary State.

11      “(b) SECONDARY STATE’S AUTHORITY.—Nothing in  
12      subsection (a) shall be construed to affect the authority  
13      of a secondary State to enforce its laws as set forth in  
14      the exception specified in section 2796(b)(1).

15      “(c) COURT INTERPRETATION.—In reviewing action  
16      initiated by the applicable secondary State authority, the  
17      court of competent jurisdiction shall apply the covered  
18      laws of the primary State.

19      “(d) NOTICE OF COMPLIANCE FAILURE.—In the case  
20      of individual health insurance coverage offered in a sec-  
21      ondary State that fails to comply with the covered laws  
22      of the primary State, the applicable State authority of the  
23      secondary State may notify the applicable State authority  
24      of the primary State.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to individual health insurance  
 3 coverage offered, issued, or sold after the date of the en-  
 4 actment of this Act.

5 **SEC. 325. SEVERABILITY.**

6 If any provision of this subtitle or the application of  
 7 such provision to any person or circumstance is held to  
 8 be unconstitutional, the remainder of this subtitle and the  
 9 application of the provisions of such to any other person  
 10 or circumstance shall not be affected.

11 **TITLE IV—IMPROVEMENTS TO**  
 12 **THE MEDICARE PROGRAM**  
 13 **Subtitle A—MediChoice for Seniors**

14 **SEC. 401. SETTING THE BENCHMARK EQUAL TO THE NA-**  
 15 **TIONAL AVERAGE BID.**

16 (a) SETTING BENCHMARK.—

17 (1) LOCAL PLANS.—Section 1853 of the Social  
 18 Security Act (42 U.S.C. 1395w–23) is amended—

19 (A) in subsection (j)(1)(A)—

20 (i) by striking “beginning with 2007”  
 21 and inserting “for 2007 and 2008”; and

22 (ii) by inserting “(or, beginning with  
 23 2009, an amount equal to the national av-  
 24 erage MA statutory non-drug monthly bid

1 amount computed under subsection (l))”

2 after “for the area”; and

3 (iii) by inserting “and adjusted as ap-

4 propriate (for years beginning with 2009)

5 using the geographic adjustment method-

6 ology established under subsection (m)”

7 before “; or”; and

8 (B) by adding at the end the following new

9 subsections:

10 “(l) COMPUTATION OF NATIONAL AVERAGE MA

11 STATUTORY NON-DRUG MONTHLY BID AMOUNT.—

12 “(1) IN GENERAL.—For each year (beginning

13 with 2009) the Secretary shall compute a national

14 average MA statutory non-drug monthly bid amount

15 equal to the average of the unadjusted MA statutory

16 non-drug monthly bid amount (as defined in section

17 1854(b)(2)(E)) for each MA plan, including an MA

18 regional plan.

19 “(2) WEIGHTED AVERAGE.—The national aver-

20 age MA statutory non-drug monthly bid amount

21 computed under subparagraph (A) shall be a weight-

22 ed average, with the weight for each plan being

23 equal to the average number of beneficiaries enrolled

24 under such plan in the previous year.



1       “(m) METHODOLOGY FOR GEOGRAPHICALLY AD-  
 2 JUSTING THE NATIONAL AVERAGE MA STATUTORY NON-  
 3 DRUG MONTHLY BID AMOUNT.—

4           “(1) IN GENERAL.—Subject to paragraph (2),  
 5 the Secretary shall establish an appropriate method-  
 6 ology for adjusting the amount of the national aver-  
 7 age MA statutory non-drug monthly bid amount in  
 8 a year to take into account, in a budget neutral  
 9 manner, variations in input costs based on the provi-  
 10 sion of items and services in different geographic  
 11 areas.

12          “(2) MAXIMIZE PLAN PARTICIPATION.—The  
 13 Secretary shall establish the methodology under  
 14 paragraph (1) in a manner that maximizes partici-  
 15 pation of plans in the program under this part.”.

16          (2) REGIONAL PLANS.—Section 1858(f)(1) of  
 17 the Social Security Act (42 U.S.C. 1395w-  
 18 27a(f)(1)) is amended to read as follows:

19          “(1) COMPUTATION FOR REGIONS.—For pur-  
 20 poses of section 1853(j)(2) and this section, subject  
 21 to subsection (e), the term ‘MA region-specific non-  
 22 drug monthly benchmark amount’ means, with re-  
 23 spect to an MA region for a month in a year—

1           “(A) for 2006, 2007, and 2008, the sum  
2           of the 2 components described in paragraph (2)  
3           for the region and year; and

4           “(B) for 2009 and each subsequent year,  
5           the national average MA statutory non-drug  
6           monthly bid amount computed under section  
7           1853(l) as adjusted as appropriate using the  
8           geographic adjustment methodology established  
9           under section 1853(m).

10          The Secretary shall compute such benchmark  
11          amount for each MA region before the beginning of  
12          each annual, coordinated election period under sec-  
13          tion 1851(e)(3)(B) for each year (beginning with  
14          2006)”.  
15

            (3)           CONFORMING           AMENDMENTS.—  
16          1853(b)(1)(B) of the Social Security Act (42 U.S.C.  
17          1395w-23(b)(1)(B)) is amended—

18                 (A) in clause (i)(I), by inserting “and the  
19                 MA area-specific non-drug monthly benchmark  
20                 amount under subsection (j), including the geo-  
21                 graphic adjusters under subsection (l) to be  
22                 used in computing such amount, for each MA  
23                 payment area for the year” before the period at  
24                 the end; and

1 (B) in clause (ii), by inserting “, including  
 2 the geographic adjusters under section 1853(l)  
 3 to be used in computing such amount” before  
 4 the period at the end.

5 (b) STUDY AND REPORT TO CONGRESS.—

6 (1) REVIEW.—Not less frequently that once  
 7 every five years, the Secretary of Health and Human  
 8 Services shall conduct a review that compares—

9 (A) the national average MA statutory  
 10 non-drug monthly bid amount (as determined  
 11 under subsection (l) of section 1853 of the So-  
 12 cial Security Act (42 U.S.C. 1395w–23), as  
 13 added by subsection (a)); and

14 (B) the average per capita cost for the  
 15 United States, as estimated by the Secretary  
 16 under section 1876(a)(4) of such Act (42  
 17 U.S.C. 1395mm(a)(4)).

18 (2) REPORT TO CONGRESS.—The Secretary of  
 19 Health and Human Services shall submit a report to  
 20 Congress on each review conducted under paragraph  
 21 (1).

22 **SEC. 402. ENHANCEMENT OF BENEFICIARY REBATES.**

23 Section 1854(b)(1)(C)(i) of the Social Security Act  
 24 (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by insert-

ing “(or 100 percent in the case of plan years beginning on or after January 1, 2009)” after “75 percent”.

**SEC. 403. ALTERNATIVE BENEFIT DESIGN TO ORIGINAL  
MEDICARE FEE-FOR-SERVICE BENEFITS.**

Part C of title XVIII of the Social Security Act is amended by adding at the end the following new section:

“ALTERNATIVE BENEFIT DESIGN TO ORIGINAL MEDICARE  
FEE-FOR-SERVICE BENEFITS

“SEC. 1860C–2. (a) BENEFITS.—

“(1) IN GENERAL.—Notwithstanding the provisions of this part and subject to paragraph (2), beginning with 2009, under procedures established by the Secretary, a Medicare Advantage plan offered by a Medicare Advantage organization may provide different benefits than those required under section 1852(a) so long as the Secretary finds that the benefit design meets requirements under the Employee Retirement Income Security Act of 1974 or that the benefit design may be offered in any State under applicable State law.

“(2) REQUIREMENT.—A Medicare Advantage organization may not offer an alternative benefit design plan described in paragraph (1) for a year unless the organization also offers a Medicare Advantage plan that is not an alternative benefit design plan described in paragraph (1) for the year. Such

1 plan is not required to be offered in the same area  
2 as the alternative benefit design plan described in  
3 paragraph (1).

4 “(b) SPECIAL RULES.—The following rules shall  
5 apply to an alternative benefit design plan described in  
6 subsection (a)(1):

7 “(1) PAYMENT TO PLANS FOR NON-DRUG BEN-  
8 EFITS.—Payment to an organization for benefits  
9 under the plan (other than prescription drug bene-  
10 fits) shall be determined in the same manner as pay-  
11 ments are determined under clauses (i) and (ii) of  
12 section 1853(a)(1)(B), except that in applying such  
13 clauses the monthly bid amount described in para-  
14 graph (2)(B)(i) of this subsection shall be sub-  
15 stituted for the unadjusted MA statutory non-drug  
16 monthly bid amount.

17 “(2) SUBMISSION OF BIDS.—Notwithstanding  
18 paragraph (6) of section 1854(a), the information  
19 required to be submitted under such section is as  
20 follows:

21 “(A) The monthly aggregate bid amount  
22 for the provision of all items and services under  
23 the plan, which amount shall be based on aver-  
24 age revenue requirements (as used for purposes  
25 of section 1302(8) of the Public Health Service

1 Act) in the payment area for an enrollee with  
2 a national average risk profile for the factors  
3 described in section 1853(a)(1)(C) (as specified  
4 by the Secretary).

5 “(B) The proportions of such bid amount  
6 that are attributable to—

7 “(i) the provision of items and serv-  
8 ices other than prescription drug coverage;  
9 and

10 “(ii) the provision of basic prescrip-  
11 tion drug coverage and supplemental pre-  
12 scription drug coverage.

13 “(C) The actuarial basis for determining  
14 the amount under subparagraph (A) and the  
15 proportions described in subparagraph (B) and  
16 such additional information as the Secretary  
17 may require to verify such actuarial bases and  
18 the projected number of enrollees in each MA  
19 local area.

20 “(D) A description of deductibles, coinsur-  
21 ance, and copayments applicable under the plan  
22 and the actuarial value of such deductibles, co-  
23 insurance, and copayments, described in section  
24 1854(e)(4)(A).

1           “(E) With respect to qualified prescription  
 2           drug coverage, the information required under  
 3           section 1860D–4, as incorporated under section  
 4           1860D–11(b)(2), with respect to such coverage.

5           “(3) PREMIUM.—In determining the monthly  
 6           amount (if any) of the premium charged to an indi-  
 7           vidual enrolled in the plan—

8           “(A) section 1854(b) shall be applied by  
 9           substituting the monthly bid amount described  
 10          in paragraph (2)(B)(i) of this subsection for the  
 11          unadjusted MA statutory non-drug monthly bid  
 12          amount; and

13          “(B) subparagraphs (C) and (D) of para-  
 14          graph (2) of such section shall not apply.

15          “(c) APPLICATION.—

16          “(1) NO AFFECT ON SPECIAL BENEFIT RULES  
 17          FOR REGIONAL PLANS.—The provisions of this sec-  
 18          tion shall not affect the special benefit rules for MA  
 19          regional plans under section 1852(a)(6).

20          “(2) NO EFFECT ON PRESCRIPTION DRUG COV-  
 21          ERAGE.—The provisions of this section shall not ef-  
 22          fect the provision of prescription drug coverage  
 23          under this part.

24          “(3) BID NOT TAKEN INTO ACCOUNT WHEN DE-  
 25          TERMINING THE NATIONAL AVERAGE MA STATUTORY

1 NON-DRUG MONTHLY BID AMOUNT.—The bid for an  
 2 alternative benefit design plan described in sub-  
 3 section (a)(1) shall not be taken into account when  
 4 computing the national average MA statutory non-  
 5 drug monthly bid amount under section 1853(l).

6 “(d) WAIVER.—To facilitate the offering of alter-  
 7 native benefit design plans described in subsection (a)(1)  
 8 under this part, the Secretary may waive or modify re-  
 9 quirements under this part.”.

10 **SEC. 404. MEDICARE ADVANTAGE HSA PLANS.**

11 (a) PROVIDING MEDICARE ADVANTAGE HSA PLANS  
 12 AS A TYPE OF PLAN UNDER THE MEDICARE ADVANTAGE  
 13 PROGRAM.—Section 1851(a)(2) of the Social Security Act  
 14 (42 U.S.C. 1395w–21(a)(2)) is amended by adding at the  
 15 end the following new subparagraph:

16 “(D) COMBINATION OF HSA PLAN AND  
 17 CONTRIBUTIONS TO HSA.—A Medicare Advan-  
 18 tage HSA plan, as defined in section  
 19 1859(b)(7), and a contribution into a Medicare  
 20 Advantage health savings account (HSA).”.

21 (b) DEFINITION OF MEDICARE ADVANTAGE HSA  
 22 PLAN.—Section 1859(b) of the Social Security Act (42  
 23 U.S.C. 1395w–28(b)) is amended by adding at the end  
 24 the following new paragraph:

25 “(7) MEDICARE ADVANTAGE HSA PLAN.—



1           “(A) IN GENERAL.—The term ‘Medicare  
2           Advantage HSA plan’ means a Medicare Ad-  
3           vantage plan that—

4                   “(i) is a high deductible health plan  
5                   (as defined in section 223(c)(2) of the In-  
6                   ternal Revenue Code of 1986, including the  
7                   application of subparagraphs (C) and (D)  
8                   of such section);

9                   “(ii) has a service area of—

10                           “(I) not less than an entire State  
11                           or territory; or

12                           “(II) in the case of the District  
13                           of Columbia, not less than the District  
14                           of Columbia and 1 contiguous State;

15                   “(iii) provides reimbursement for at  
16                   least the items and services described in  
17                   section 1852(a)(1) in a year but only after  
18                   the enrollee incurs countable expenses (as  
19                   specified under the plan) equal to the  
20                   amount of the annual deductible (as deter-  
21                   mined under section 223(c)(2)(A)(i) of the  
22                   Internal Revenue Code of 1986);

23                   “(iv) counts as such expenses (for  
24                   purposes of such deductible) at least all  
25                   amounts that would have been payable

1 under parts A and B, and that would have  
 2 been payable by the enrollee as deductibles,  
 3 coinsurance, or copayments, if the enrollee  
 4 had elected to receive benefits through the  
 5 provisions of such parts; and

6 “(v) provides, after such deductible is  
 7 met for a year and for all subsequent ex-  
 8 penses for items and services referred to in  
 9 clause (iii) in the year, for a level of reim-  
 10 bursement that is not less than—

11 “(I) 100 percent of such ex-  
 12 penses, or

13 “(II) 100 percent of the amounts  
 14 that would have been paid (without  
 15 regard to any deductibles or coinsur-  
 16 ance) under parts A and B with re-  
 17 spect to such expenses,  
 18 whichever is less.”.

19 (c) SPECIAL RULES FOR HSA PLANS.—Part C of  
 20 title XVIII of the Social Security Act is amended by in-  
 21 serting after section 1858 the following new section:

22 “SPECIAL RULES FOR MEDICARE ADVANTAGE HSA PLANS

23 “SEC. 1858A. (a) IN GENERAL.—Except for the  
 24 modifications described in the succeeding provisions of this  
 25 section, a Medicare Advantage HSA plan shall be treated

1 in the same manner as an MSA plan is treated under this  
2 title.

3 “(b) SPECIAL PAYMENT RULES.—

4 “(1) IN GENERAL.—Section 1853(e) shall be  
5 applied—

6 “(A) in the heading, by substituting ‘HSA’  
7 for ‘MSA’;

8 “(B) in paragraph (1)—

9 “(i) by substituting ‘HSA premium  
10 (as defined in section 1858A(b)(2))’ for  
11 ‘MSA premium (as defined in section  
12 1854(b)(2)(C))’; and

13 “(ii) by substituting ‘HSA’ for ‘MSA’  
14 each place it appears;

15 “(C) in paragraph (2)—

16 “(i) in the heading, by substituting  
17 ‘HEALTH’ for ‘MEDICAL’;

18 “(ii) in the matter preceding subpara-  
19 graph (A), by substituting ‘a Medicare Ad-  
20 vantage HSA plan’ for ‘an MSA plan’;

21 “(iii) in subparagraph (A), by sub-  
22 stituting ‘HSA (as defined in section  
23 138(b) of the Internal Revenue Code of  
24 1986)’ for ‘MSA (as defined in section

1                   138(b)(2) of the Internal Revenue Code of  
2                   1986)’; and

3                   “(iv) in subparagraph (B), by sub-  
4                   stituting ‘HSA’ for ‘MSA’ each place it ap-  
5                   pears; and

6                   “(D) without regard to paragraph (3) (re-  
7                   quiring a lump-sum deposit of a medical sav-  
8                   ings account contribution during the first  
9                   month election is effective).

10                  “(2) DEFINITION OF MEDICARE ADVANTAGE  
11                  MONTHLY HSA PREMIUM.—The term ‘Medicare Ad-  
12                  vantage monthly HSA premium’ has the same mean-  
13                  ing given the term ‘Medicare Advantage monthly  
14                  MSA premium’ under section 1854(b)(2)(D).

15                  “(c) TREATMENT OF MEDICARE ADVANTAGE HSA  
16                  PLANS UNDER PART D.—Rules with respect to prescrip-  
17                  tion drug coverage under part D for MSA plans shall not  
18                  apply to a Medicare Advantage HSA plan. For purposes  
19                  of part D, a Medicare Advantage HSA plan shall be treat-  
20                  ed in the same manner as a coordinated care plan (as de-  
21                  scribed in section 1851(a)(2)(A)(i)) is treated under such  
22                  part.”.

23                  (d) TAX TREATMENT OF MEDICARE ADVANTAGE  
24                  HSA PLANS.—

1           (1) IN GENERAL.—Part III of subchapter B of  
 2           chapter 1 of the Internal Revenue Code of 1986 is  
 3           amended by inserting after section 139A the fol-  
 4           lowing new section:

5   **“SEC. 139B. MEDICARE ADVANTAGE HSA.**

6           “(a) EXCLUSION.—Gross income shall not include—

7               “(1) any payment to the Medicare Advantage  
 8           HSA of an individual by the Secretary of Health  
 9           and Human Services under part C of title XVIII of  
 10          the Social Security Act,

11               “(2) any amount contributed to such Medicare  
 12          Advantage HSA by or on behalf of the individual  
 13          under section 223, including the individual’s em-  
 14          ployer as described in section 106(d), and

15               “(3) an amount equal to any one-time qualified  
 16          rollover from any of the individual’s health savings  
 17          accounts, health reimbursement accounts, flexible  
 18          spending accounts, and medical savings accounts  
 19          (including any Medicare Advantage MSA).

20          “(b) MEDICARE ADVANTAGE HSA.—For purposes of  
 21          this section, the term ‘Medicare Advantage HSA’ means  
 22          a health savings account (as defined in section 223(d))—

23               “(1) which is designated as a Medicare Advan-  
 24          tage HSA,

1 “(2) with respect to which no contribution may  
2 be made other than—

3 “(A) a contribution described in subsection  
4 (a), or

5 “(B) a trustee-to-trustee transfer described  
6 in subsection (c)(4),

7 “(3) the governing instrument of which pro-  
8 vides that trustee-to-trustee transfers described in  
9 subsection (c)(4) may be made to and from such ac-  
10 count, and

11 “(4) which is established in connection with an  
12 HSA plan described in section 1859(b)(7) of the So-  
13 cial Security Act.

14 “(c) SPECIAL RULES FOR DISTRIBUTIONS.—

15 “(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL  
16 EXPENSES.—In applying section 223 to a Medicare  
17 Advantage HSA, qualified medical expenses shall not  
18 include amounts paid for medical care for any indi-  
19 vidual other than the account holder.

20 “(2) PENALTY FOR DISTRIBUTIONS FROM  
21 MEDICARE ADVANTAGE HSA NOT USED FOR QUALI-  
22 FIED MEDICAL EXPENSES IF MINIMUM BALANCE  
23 NOT MAINTAINED.—

24 “(A) IN GENERAL.—The tax imposed by  
25 this chapter for any taxable year in which there

1 is a payment or distribution from a Medicare  
 2 Advantage HSA which is not used exclusively to  
 3 pay the qualified medical expenses of the ac-  
 4 count holder shall be increased by 50 percent of  
 5 the excess (if any) of—

6 “(i) the amount of such payment or  
 7 distribution, over

8 “(ii) the excess (if any) of—

9 “(I) the fair market value of the  
 10 assets in such HSA as of the close of  
 11 the calendar year preceding the cal-  
 12 endar year in which the taxable year  
 13 begins, over

14 “(II) an amount equal to 60 per-  
 15 cent of the deductible under the Medi-  
 16 care Advantage HSA plan covering  
 17 the account holder as of January 1 of  
 18 the calendar year in which the taxable  
 19 year begins.

20 Section 223(f)(4) shall not apply to any  
 21 payment or distribution from a Medicare  
 22 Advantage HSA.

23 “(B) EXCEPTIONS.—Subparagraph (A)  
 24 shall not apply if the payment or distribution is  
 25 made on or after the date the account holder—

1 “(i) becomes disabled within the  
2 meaning of section 72(m)(7), or

3 “(ii) dies.

4 “(C) SPECIAL RULES.—For purposes of  
5 subparagraph (A)—

6 “(i) all Medicare Advantage HSAs of  
7 the account holder shall be treated as 1 ac-  
8 count,

9 “(ii) all payments and distributions  
10 not used exclusively to pay the qualified  
11 medical expenses of the account holder  
12 during any taxable year shall be treated as  
13 1 distribution, and

14 “(iii) any distribution of property  
15 shall be taken into account at its fair mar-  
16 ket value on the date of the distribution.

17 “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-  
18 TIONS.—Section 223(f)(2) and paragraph (2) of this  
19 subsection shall not apply to any payment or dis-  
20 tribution from a Medicare Advantage HSA to the  
21 Secretary of Health and Human Services of an erro-  
22 neous contribution to such HSA and of the net in-  
23 come attributable to such contribution.

24 “(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Sec-  
25 tion 223(f)(2) and paragraph (2) of this subsection



1       shall not apply to any trustee-to-trustee transfer  
 2       from a Medicare Advantage HSA of an account  
 3       holder to another Medicare Advantage HSA of such  
 4       account holder.

5       “(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT  
 6 AFTER DEATH OF ACCOUNT HOLDER.—In applying sec-  
 7 tion 223(f)(8)(A) to an account which was a Medicare Ad-  
 8 vantage HSA of a decedent, the rules of section 223(f)  
 9 shall apply in lieu of the rules of subsection (c) of this  
 10 section with respect to the spouse as the account holder  
 11 of such Medicare Advantage HSA.

12       “(e) REPORTS.—In the case of a Medicare Advantage  
 13 HSA, the report under section 223(h)—

14               “(1) shall include the fair market value of the  
 15       assets in such Medicare Advantage HSA as of the  
 16       close of each calendar year, and

17               “(2) shall be furnished to the account holder—

18                       “(A) not later than January 31 of the cal-  
 19       endar year following the calendar year to which  
 20       such reports relate, and

21                       “(B) in such manner as the Secretary pre-  
 22       scribes in such regulations.”.

23       (2) CLERICAL AMENDMENT.—The table of sec-  
 24       tions for part III of subchapter B of chapter 1 of

1       such Code is amended by inserting after the item re-  
 2       lating to section 139A the following new item:

“Sec. 139B. Medicare Advantage HSA.”.

3       (e) EFFECTIVE DATE.—The amendments made by  
 4 this section shall take effect on January 1, 2009.

5 **SEC. 405. REVIEW OF ADJUSTMENT MECHANISM USED**  
 6 **UNDER THE MEDICARE ADVANTAGE PRO-**  
 7 **GRAM.**

8       (a) REVIEW.—Not later than 1 year after the date  
 9 of enactment of this Act, the Secretary of Health and  
 10 Human Services shall conduct a review of the adjustment  
 11 mechanism used to adjust payments to Medicare Advan-  
 12 tage organizations under section 1853(a)(1)(C) of the So-  
 13 cial Security Act (42 U.S.C. 1395w–23(a)(1)(C)). The  
 14 Secretary shall take into account the results of such review  
 15 in making payments to Medicare Advantage organizations  
 16 for plan years beginning on or after January 1, 2009.

17       (b) CONSULTATION.—In conducting the review under  
 18 subsection (a), the Secretary of Health and Human Serv-  
 19 ices shall consult with industry representatives and other  
 20 individuals and organizations that the Secretary deter-  
 21 mines appropriate.

**1     Subtitle B—Enhancements to the**  
**2     Medicare Fee-For-Service Program**

**3     SEC. 411. ELIMINATION OF ANNUAL INDEXING OF INCOME**  
**4                     THRESHOLDS FOR REDUCED PART B PRE-**  
**5                     MIUM SUBSIDIES.**

**6             Paragraph (5) of section 1839(i) of the Social Secu-**  
**7     rity Act (42 U.S.C. 1395r(i)) is repealed.**

**8     SEC. 412. AUTHORITY TO ADJUST AMOUNT OF MEDICARE**  
**9                     PART B PREMIUM TO REWARD POSITIVE**  
**10                    HEALTH BEHAVIOR.**

**11           Section 1839 of the Social Security Act (42 U.S.C.**  
**12     1395r) is amended—**

**13                     (1) in subsection (a)(2), by striking “and (i)”**  
**14                     and inserting “(i), and (j)”;** and

**15                     (2) by adding at the end the following new sub-**  
**16                     section:**

**17             “(j)(1) With respect to the monthly premium amount**  
**18     for months after December 2008, the Secretary may ad-**  
**19     just (under procedures established by the Secretary) the**  
**20     amount of such premium for an individual based on**  
**21     whether or not the individual participates in certain**  
**22     healthy behaviors, such as weight management, exercise,**  
**23     nutrition counseling, refraining from tobacco use, desig-**  
**24     nating a health home, and other behaviors determined ap-**  
**25     propriate by the Secretary.**

1 “(2) In making the adjustments under paragraph (1)  
 2 for a month, the Secretary shall ensure that the total  
 3 amount of premiums to be paid under this part for the  
 4 month is equal to the total amount of premiums that  
 5 would have been paid under this part for the month if  
 6 no such adjustments had been made, as estimated by the  
 7 Secretary.”.

8 **SEC. 413. RECAPTURE OF MEDICARE DSH FUNDS.**

9 (a) IN GENERAL.—Section 1886(d)(5)(F)(i) of the  
 10 Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(i)) is  
 11 amended by inserting “and before January 1, 2010,” after  
 12 “May 1, 1986,”.

13 (b) SAVINGS TO PART A TRUST FUND.—The savings  
 14 to the Federal Hospital Insurance Trust Fund under sec-  
 15 tion 1817 of the Social Security Act (42 U.S.C. 1395i)  
 16 by reason of the amendment made by paragraph (1) shall  
 17 be used to strengthen the financial solvency of such Trust  
 18 Fund.

19 **SEC. 414. PRICE TRANSPARENCY REQUIREMENTS FOR**  
 20 **MEDICARE PROVIDERS.**

21 (a) TRANSPARENCY.—Title XVIII of the Social Secu-  
 22 rity Act is amended by adding at the end the following  
 23 new section:

24 “PRICE TRANSPARENCY REQUIREMENTS

25 “SEC. 1898. (a) PRE-TREATMENT DISCLOSURE.—A  
 26 provider of services (as defined in section 1861(u)) and

1 a supplier (as defined in section 1861(d)) shall provide  
2 to each individual (regardless of whether or not the indi-  
3 vidual is a beneficiary under this title) who is scheduled  
4 to receive a treatment (or to begin a course of treatment)  
5 that is not for an emergency medical condition the esti-  
6 mated price that the provider of services or supplier will  
7 charge for the treatment (or course of treatment). Such  
8 price shall be determined at the time of scheduling.

9 “(b) POST-TREATMENT DISCLOSURE.—A provider of  
10 services (as so defined) and a supplier (as so defined) shall  
11 include with any bill that includes the charges for a treat-  
12 ment with respect to an individual (regardless of whether  
13 or not the individual is a beneficiary under this title), an  
14 itemized list of component charges for such treatment, in-  
15 cluding charges for drugs and medical equipment involved,  
16 as determined at the time of billing. With respect to each  
17 item included on such list, the provider of services or sup-  
18 plier shall include the price charged for the item.”.

19 (b) EFFECTIVE DATE.—The amendment made by  
20 subsection (a) shall apply to providers of services and sup-  
21 pliers on and after January 1, 2009.

## **Subtitle C—Value-Based Purchasing**

### **SEC. 421. REPEAL OF PHYSICIAN OWNERSHIP REFERRAL PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.**

(a) IN GENERAL.—Section 1877(a)(2) of the Social Security Act (42 U.S.C. 1395nn(a)(2)) is amended by striking “is—” and all that follows through “equity,” and inserting the following: “is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,”.

(b) CONFORMING AMENDMENTS.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking “TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS” and inserting “WHERE FINANCIAL RELATIONSHIP EXISTS”; and

(B) by redesignating paragraphs (4) and (5) as paragraphs (7) and (8).

(2) In subsection (c)—

(A) by amending the heading to read as follows: “EXCEPTION FOR OWNERSHIP OR IN-

1 VESTMENT INTEREST IN PUBLICLY TRADED  
2 SECURITIES AND MUTUAL FUNDS”; and

3 (B) in the matter preceding paragraph (1),  
4 by striking “subsection (a)(2)(A)” and inserting  
5 “subsection (a)(2)”.

6 (3) In subsection (d)—

7 (A) by striking the heading and the matter  
8 preceding paragraph (1);

9 (B) in paragraph (3), by striking “para-  
10 graph (1)” and inserting “paragraph (4)”; and

11 (C) by redesignating paragraphs (1), (2),  
12 and (3) as paragraphs (4), (5), and (6), and by  
13 transferring and inserting such paragraphs  
14 after paragraph (3) of subsection (b).

15 (4) By striking subsection (e).

16 (5) In subsection (f)—

17 (A) in the matter preceding paragraph (1),  
18 by striking “ownership, investment, and com-  
19 pensation” and inserting “ownership and in-  
20 vestment”; and

21 (B) in paragraph (2)—

22 (i) by striking “subsection (a)(2)(A)”  
23 and all that follows through “subsection  
24 (a)(2)(B)),” and inserting “subsection  
25 (a)(2)),”; and

1 (ii) in paragraph (2), by striking “or  
 2 who have such a compensation relationship  
 3 with the entity”.

4 (6) In subsection (h)—

5 (A) by striking paragraphs (1), (2), and  
 6 (3);

7 (B) in paragraph (4)(A)—

8 (i) by striking clauses (iv) and (vi);

9 (ii) in clause (iii), by adding “and” at  
 10 the end;

11 (iii) by redesignating clause (v) as  
 12 clause (iv); and

13 (iv) in clause (iv), as redesignated by  
 14 clause (iii), by striking “, and” and insert-  
 15 ing a period;

16 (C) in paragraph (4)(B), by striking  
 17 “RULES.—” and all that follows through “(ii)  
 18 FACULTY” and inserting “RULES FOR FAC-  
 19 ULTY”; and

20 (D) by adding at the end of paragraph (4)  
 21 the following new subparagraph:

22 “(C) MEMBER OF A GROUP.—A physician  
 23 is a ‘member’ of a group if the physician is an  
 24 owner or a bona fide employee, or both, of the  
 25 group.”.



1 **SEC. 422. REVISION OF DESIGNATED HEALTH SERVICES**  
 2 **SUBJECT TO OWNERSHIP REFERRAL PROHI-**  
 3 **BITION.**

4 (a) IN GENERAL.—Section 1877(h)(6) of the Social  
 5 Security Act (42 U.S.C. 1395nn(h)(6)) is amended by  
 6 striking subparagraphs (B) through (K) and inserting the  
 7 following:

8 “(B) Parenteral and enteral nutrients,  
 9 equipment, and supplies.

10 “(C) Radiology services, including mag-  
 11 netic resonance imaging, computerized tomog-  
 12 raphy, and ultrasound services.

13 “(D) Outpatient physical or occupational  
 14 therapy services.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) Section 1877(b)(2) of the Social Security  
 17 Act (42 U.S.C. 1395nn(b)(2)), in the matter pre-  
 18 ceding subparagraph (A), is amended by striking  
 19 “services” and all that follows through “supplies)—  
 20 ” and inserting “services—”.

21 (2) Section 1877(h)(5)(C) of the Social Secu-  
 22 rity Act (42 U.S.C. 1395nn(h)(5)(C)) is amended—

23 (A) by striking “, a request by a radiolo-  
 24 gist for diagnostic radiology services, and a re-  
 25 quest by a radiation oncologist for radiation  
 26 therapy,” and inserting “and a request by a ra-

diologist for magnetic resonance imaging or for  
computerized tomography”; and

(B) by striking “radiologist, or radiation  
oncologist” and inserting “or radiologist”.

**SEC. 423. EXCEPTIONS TO OWNERSHIP REFERRAL PROHIBITIONS.**

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(A) in subsection (b)(2), by striking subparagraph (A) and inserting the following new subparagraph:

“(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice; and”, and

(B) in subsection (h), by adding at the end following new paragraph:

“(8) GENERAL SUPERVISION.—An individual is considered to be under the ‘general supervision’ of a

1 physician if the physician (or group practice of  
 2 which the physician is a member) is legally respon-  
 3 sible for the services performed by the individual and  
 4 for ensuring that the individual meets licensure and  
 5 certification requirements, if any, applicable under  
 6 other provisions of law, regardless of whether or not  
 7 the physician is physically present when the indi-  
 8 vidual furnishes an item or service.”.

9 (2) CLARIFICATION OF TREATMENT OF PHYSI-  
 10 CIAN OWNERS OF GROUP PRACTICE.—Section  
 11 1877(b)(2)(B) of the Social Security Act (42 U.S.C.  
 12 1395nn(b)(2)(B)) is amended by striking “physician  
 13 or such group practice” and inserting “physician,  
 14 such group practice, or the physician owners of such  
 15 group practice”.

16 (3) CONFORMING AMENDMENT.—The heading  
 17 of section 1877(b)(2) of the Social Security Act (42  
 18 U.S.C. 1395nn(b)(2)) is amended by striking “IN-  
 19 OFFICE ANCILLARY SERVICES” and inserting “AN-  
 20 CILLARY SERVICES FURNISHED PERSONALLY OR  
 21 THROUGH GROUP PRACTICE”.

22 (b) CLARIFICATION OF EXCEPTION FOR SERVICES  
 23 FURNISHED IN A RURAL AREA.—Paragraph (5)(A) of  
 24 section 1877(b) of the Social Security Act (42 U.S.C.  
 25 1395nn(b)), as transferred by section 421(b)(3)(C), is

1 amended by striking “substantially all” and inserting “not  
2 less than 75 percent”.

3 (c) REVISION OF EXCEPTION FOR CERTAIN MAN-  
4 AGED CARE ARRANGEMENTS.—Section 1877(b)(3) of the  
5 Social Security Act (42 U.S.C. 1395nn(b)(3)) is amend-  
6 ed—

7 (1) in the heading by inserting “; MANAGED  
8 CARE ARRANGEMENTS” after “PREPAID PLANS”;

9 (2) in the matter preceding subparagraph (A),  
10 by striking “organization—” and inserting “organi-  
11 zation, directly or through contractual arrangements  
12 with other entities, to individuals enrolled with the  
13 organization—”;

14 (3) in subparagraph (A), by inserting “or part  
15 C” after “section 1876”;

16 (4) in subparagraph (D), by striking “or” at  
17 the end;

18 (5) in subparagraph (E), by striking the period  
19 at the end and inserting “or which provides or ar-  
20 ranges for the provision of health care items or serv-  
21 ices pursuant to a written agreement between the or-  
22 ganization and an individual or entity if the written  
23 agreement places the individual or entity at substan-  
24 tial financial risk for the cost or utilization of the  
25 items or services which the individual or entity is ob-

1       ligated to provide, whether through a withhold, capi-  
 2       tation, incentive pool, per diem payment, or any  
 3       other similar risk arrangement which places the in-  
 4       dividual or entity at substantial financial risk, or”;  
 5       and

6               (6) by adding at the end the following new sub-  
 7       paragraph:

8               “(E) with a contract with a State to pro-  
 9       vide services under the State plan under title  
 10       XIX (in accordance with section 1903(m)).”.

11       (d) NEW EXCEPTION FOR SHARED FACILITY SERV-  
 12       ICES.—

13               (1) IN GENERAL.—Section 1877(b) of the So-  
 14       cial Security Act (42 U.S.C. 1395nn(b)), as amend-  
 15       ed by paragraphs (1)(B) and (3)(C) of section  
 16       421(b), is amended—

17               (A) by redesignating paragraphs (4)  
 18       through (8) as paragraphs (5) through (9); and

19               (B) by inserting after paragraph (3) the  
 20       following new paragraph:

21               “(4) SHARED FACILITY SERVICES.—In the case  
 22       of a designated health service consisting of a shared  
 23       facility service of a shared facility—

24               “(A) that is furnished—

1 “(i) personally by the referring physi-  
 2 cian who is a shared facility physician or  
 3 personally by an individual directly em-  
 4 ployed by or under the general supervision  
 5 of such a physician;

6 “(ii) by a shared facility in a building  
 7 in which the referring physician furnishes  
 8 substantially all of the services of the phy-  
 9 sician that are unrelated to the furnishing  
 10 of shared facility services; and

11 “(iii) to a patient of a shared facility  
 12 physician; and

13 “(B) that is billed by the referring physi-  
 14 cian or a group practice of which the physician  
 15 is a member.”.

16 (2) DEFINITIONS.—Section 1877(h) of the So-  
 17 cial Security Act (42 U.S.C. 1395nn(h)), as amend-  
 18 ed by section 421(b)(6), is amended by inserting be-  
 19 fore paragraph (4) the following new paragraph:

20 “(1) SHARED FACILITY RELATED DEFINI-  
 21 TIONS.—

22 “(A) SHARED FACILITY SERVICE.—The  
 23 term ‘shared facility service’ means, with re-  
 24 spect to a shared facility, a designated health

1 service furnished by the facility to patients of  
2 shared facility physicians.

3 “(B) SHARED FACILITY.—The term  
4 ‘shared facility’ means an entity that furnishes  
5 shared facility services under a shared facility  
6 arrangement.

7 “(C) SHARED FACILITY PHYSICIAN.—The  
8 term ‘shared facility physician’ means, with re-  
9 spect to a shared facility, a physician (or a  
10 group practice of which the physician is a mem-  
11 ber) who has a financial relationship under a  
12 shared facility arrangement with the facility.

13 “(D) SHARED FACILITY ARRANGEMENT.—  
14 The term ‘shared facility arrangement’ means,  
15 with respect to the provision of shared facility  
16 services in a building, a financial arrange-  
17 ment—

18 “(i) which is only between physicians  
19 who are providing services (unrelated to  
20 shared facility services) in the same build-  
21 ing;

22 “(ii) in which the overhead expenses  
23 of the facility are shared, in accordance  
24 with methods previously determined by the

1 physicians in the arrangement, among the  
 2 physicians in the arrangement; and  
 3 “(iii) which, in the case of a corpora-  
 4 tion, is wholly owned and controlled by  
 5 shared facility physicians.”.

6 (e) NEW EXCEPTION FOR SERVICES FURNISHED IN  
 7 COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—  
 8 Section 1877(b) of the Social Security Act (42 U.S.C.  
 9 1395nn(b)), as amended by paragraphs (1)(B) and (3)(C)  
 10 of section 421(b) and subsection (d)(1), is amended—

11 (1) by redesignating paragraphs (5) through  
 12 (9) as paragraphs (6) through (10); and

13 (2) by inserting after paragraph (4) the fol-  
 14 lowing new paragraph:

15 “(5) NO ALTERNATIVE PROVIDERS IN AREA.—  
 16 In the case of a designated health service furnished  
 17 in any area with respect to which the Secretary de-  
 18 termines that individuals residing in the area do not  
 19 have reasonable access to such a designated health  
 20 service for which subsection (a)(1) does not apply.”.

21 (f) NEW EXCEPTION FOR SERVICES FURNISHED IN  
 22 AMBULATORY SURGICAL CENTERS.—Section 1877(b) of  
 23 the Social Security Act (42 U.S.C. 1395nn(b)), as amend-  
 24 ed by paragraphs (1)(B) and (3)(C) of section 421(b),  
 25 subsection (d)(1), and subsection (e)(1), is amended—



1           (1) by redesignating paragraphs (6) through  
2           (10) as paragraphs (7) through (11); and

3           (2) by inserting after paragraph (5) the fol-  
4           lowing new paragraph:

5           “(6) SERVICES FURNISHED IN AMBULATORY  
6           SURGICAL CENTERS.—In the case of a designated  
7           health service furnished in an ambulatory surgical  
8           center described in section 1832(a)(2)(F)(i).”.

9           (g) NEW EXCEPTION FOR SERVICES FURNISHED IN  
10          RENAL DIALYSIS FACILITIES.—Section 1877(b) of the  
11          Social Security Act (42 U.S.C. 1395nn(b)), as amended  
12          by paragraphs (1)(B) and (3)(C) of section 421(b), sub-  
13          section (d)(1), subsection (e)(1), and subsection (f), is  
14          amended—

15               (1) by redesignating paragraphs (7) through  
16               (11) as paragraphs (8) through (12); and

17               (2) by inserting after paragraph (6) the fol-  
18               lowing new paragraph:

19               “(7) SERVICES FURNISHED IN RENAL DIALYSIS  
20               FACILITIES.—In the case of a designated health  
21               service furnished in a renal dialysis facility under  
22               section 1881.”.

23           (h) NEW EXCEPTION FOR SERVICES FURNISHED IN  
24          A HOSPICE.—Section 1877(b) of the Social Security Act  
25          (42 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B)

1 and (3)(C) of section 421(b), subsection (d)(1), subsection  
 2 (e)(1), subsection (f), and subsection (g), is amended—

3 (1) by redesignating paragraphs (8) through  
 4 (12) as paragraphs (9) through (13); and

5 (2) by inserting after paragraph (7) the fol-  
 6 lowing new paragraph:

7 “(8) SERVICES FURNISHED BY A HOSPICE PRO-  
 8 GRAM.—In the case of a designated health service  
 9 furnished by a hospice program (as defined in sec-  
 10 tion 1861(dd)(2)).”.

11 (i) NEW EXCEPTION FOR SERVICES FURNISHED IN  
 12 A COMPREHENSIVE OUTPATIENT REHABILITATION FA-  
 13 CILITY.—Section 1877(b) of the Social Security Act (42  
 14 U.S.C. 1395nn(b)), as amended by paragraphs (1)(B) and  
 15 (3)(C) of section 421(b), subsection (d)(1), subsection  
 16 (e)(1), subsection (f), subsection (g), and subsection (h),  
 17 is amended—

18 (1) by redesignating paragraphs (9) through  
 19 (13) as paragraphs (10) through (14); and

20 (2) by inserting after paragraph (8) the fol-  
 21 lowing new paragraph:

22 “(9) SERVICES FURNISHED IN A COMPREHEN-  
 23 SIVE OUTPATIENT REHABILITATION FACILITY.—In  
 24 the case of a designated health service furnished in

1 a comprehensive outpatient rehabilitation facility (as  
2 defined in section 1861(cc)(2)).”.

3 (j) DEFINITION OF REFERRAL.—Section  
4 1877(h)(5)(A) of the Social Security Act (42 U.S.C.  
5 1395nn(h)(5)(A)) is amended—

6 (1) by striking “an item or service” and insert-  
7 ing “a designated health service”; and

8 (2) by striking “the item or service” and insert-  
9 ing “the designated health service”.

10 (k) CONFORMING AMENDMENT.—Section  
11 1877(g)(6)(B) of the Social Security Act (42 U.S.C.  
12 1395nn(g)(6)(B)) is amended by striking “subsection  
13 (b)(4)” and inserting “subsection (b)(13)”.

14 (l) TRANSPARENCY.—The Secretary of Health and  
15 Human Services shall establish procedures for requiring  
16 a physician making a referral to an entity that would have  
17 been prohibited under section 1877 of the Social Security  
18 Act (42 U.S.C. 1395nn) if the amendments made by this  
19 section had not been made to disclose to the individual  
20 being referred the financial relationship that the physician  
21 has with the entity.

22 **SEC. 424. EFFECTIVE DATE.**

23 The amendments made by this subtitle shall apply to  
24 referrals made on or after the date of the enactment of

1 this Act, regardless of whether or not regulations are pro-  
 2 mulgated to carry out such amendments.

3 **Subtitle D—Securing Medicare’s**  
 4 **Future for Tomorrow’s Seniors**

5 **SEC. 431. MEDICAL RETIREMENT ACCOUNTS.**

6 (a) IN GENERAL.—Title II of the Social Security Act  
 7 (42 U.S.C. 401 et seq.) is amended—

8 (1) by inserting before section 201 the fol-  
 9 lowing:

10 **“PART A—INSURANCE BENEFITS”;**

11 and

12 (2) by adding at the end the following:

13 **“PART B—MEDICAL RETIREMENT ACCOUNTS**

14 **“SEC. 251. MEDICAL RETIREMENT ACCOUNT FUND.**

15 **“(a) ESTABLISHMENT.—**

16 **“(1) IN GENERAL.—**There shall be established  
 17 and maintained in the Treasury of the United States  
 18 a Medical Retirement Account Fund in the same  
 19 manner as the Thrift Savings Fund under section  
 20 8437 of title 5, United States Code (excluding para-  
 21 graphs (4) and (5) of subsection (c) thereof).

22 **“(2) CONTENTS OF FUND.—**There is hereby ap-  
 23 propriated to the Medical Retirement Account Fund  
 24 amounts equivalent to—

1           “(A) the contributions received in the  
 2           Treasury under sections 3101(b), 3111(b), and  
 3           1401(b) of the Internal Revenue Code of 1986  
 4           with respect to each eligible individual on and  
 5           after the date of an election under section  
 6           252(a)(2), and

7           “(B) the aggregate of the contributions de-  
 8           scribed in subparagraphs (B)(, (C), and (D) of  
 9           section 252(c)(1) with respect to such eligible  
 10          individuals.

11          “(b) INVESTMENT OF MEDICAL RETIREMENT AC-  
 12          COUNT FUND.—Amounts in the Medical Retirement Ac-  
 13          count Fund shall be invested in the same manner as  
 14          amounts in the Thrift Savings Fund are invested under  
 15          section 8438 of title 5, United States Code.

16          “(c) ACCOUNTING AND INFORMATION.—The Execu-  
 17          tive Director of the Medical Retirement Account Board  
 18          shall maintain accounts and provide information in the  
 19          same manner as the Executive Director of the Thrift Sav-  
 20          ings Fund is required to maintain accounts and provide  
 21          information with respect to the Thrift Savings Fund under  
 22          section 8439 of title 5, United States Code.

23          **“SEC. 252. MEDICAL RETIREMENT ACCOUNTS.**

24          “(a) ESTABLISHMENT.—

1           “(1) IN GENERAL.—Within 30 days after re-  
2           ceiving the first contribution under subsection (c)  
3           with respect to an eligible individual, the Medical  
4           Retirement Account Board shall establish a Medical  
5           Retirement Account for such individual in the Med-  
6           ical Retirement Account Fund. Each account shall  
7           be identified to the account holder by means of the  
8           account holder’s social security account number.

9           “(2) ELIGIBLE INDIVIDUAL.—For purposes of  
10          this part, the term ‘eligible individual’ means any in-  
11          dividual who, under regulations prescribed by the  
12          Secretary of Health and Human Services, makes an  
13          irrevocable election on or after the effective date of  
14          this part to renounce eligibility under the Medicare  
15          Program under title XVIII and establish a Medical  
16          Retirement Account.

17          “(b) TREATMENT OF ACCOUNT.—Except as provided  
18          in this section, a Medical Retirement Account shall be  
19          treated for purposes of the Internal Revenue Code of 1986  
20          in the same manner as a health savings account under  
21          section 223 of such Code (determined without regard to  
22          subsections (d)(1)(A)(ii) and (d)(2)(B) thereof).

23          “(c) CONTRIBUTIONS.—

1           “(1) IN GENERAL.—The Medical Retirement  
2       Account Board shall credit to the Medical Retirement  
3       Account of an eligible individual—

4           “(A) except as provided in paragraph (2),  
5       an amount equal to the sum of any amounts  
6       transferred to the Medical Retirement Account  
7       Fund under section 251(a)(2)(A) which are at-  
8       tributable to the contributions paid by or on be-  
9       half of such individual under sections 3101(b),  
10      3111(b), and 1401(b) of the Internal Revenue  
11      Code of 1986, plus

12          “(B) at the time of such individual’s retire-  
13      ment date determined under subsection (d)(1),  
14      an amount equal to the sum of any amounts  
15      transferred to the Federal Hospital Insurance  
16      Trust Fund under section 1817 which is attrib-  
17      utable to such contributions paid on average by  
18      or on behalf of individuals in the same age co-  
19      hort as such eligible individual under sections  
20      3101(b), 3111(b), and 1401(b) of the Internal  
21      Revenue Code of 1986 (including any Trust  
22      Fund earnings on such amount), plus

23          “(C) any amount contributed to such Med-  
24      ical Retirement Account by the eligible indi-  
25      vidual or the eligible individual’s employer, in-

cluding, in the case of an eligible individual who is a State government employee, any contribution under an applicable State law, to the extent the aggregate amount of contributions under this subparagraph for any calendar year does not exceed \$10,000, adjusted for inflation in the same manner as the applicable dollar amount under section 402(g)(1)(B) of the Internal Revenue Code of 1986, and reduced in the same manner as under section 408A(c)(3) of such Code, plus

“(D) an amount equal to any one-time qualified rollover at the time of such individual’s retirement from any of the eligible individual’s health savings accounts, health reimbursement accounts, flexible spending accounts, and medical savings accounts.

“(2) REDISTRIBUTION.—Not later than 90 days after the end of each taxable year, the Secretary shall transfer such portion of the contributions paid under section 3111(b) or 1401(b) of the Internal Revenue Code of 1986 by or on behalf of eligible individuals whose wages or net earnings from self-employment exceed the contribution and benefit base under section 230 for such taxable year to Medical



1 Retirement Accounts of eligible individuals whose  
 2 wages and net earnings from self-employment do not  
 3 exceed such base for such taxable year in an amount  
 4 per each Medical Retirement Account so as not to  
 5 exceed 2.9 percent of the national average salary for  
 6 each such Account.

7 “(d) DISTRIBUTIONS.—

8 “(1) IN GENERAL.—Except as provided in para-  
 9 graph (2), distributions may only be made from a  
 10 Medical Retirement Account of an eligible individual  
 11 on and after the date the eligible individual at-  
 12 tains—

13 “(A) retirement age (as determined under  
 14 section 216), or

15 “(B) if elected by such individual, early re-  
 16 tirement age, but only if such individual pre-  
 17 sents proof of the purchase of a lifetime cata-  
 18 strophic health insurance policy upon such elec-  
 19 tion.

20 “(2) DISTRIBUTION IN THE EVENT OF DEATH  
 21 BEFORE THE DATE OF INITIAL DISTRIBUTION.—If  
 22 the eligible individual dies before the date deter-  
 23 mined under paragraph (1), the balance in such in-  
 24 dividual’s Medical Retirement Account shall be dis-

1       tributed in a lump sum, under rules established by  
2       the Medical Retirement Account Board—

3               “(A) to the Medical Retirement Account of  
4               a surviving spouse of such individual, and

5               “(B) in the case there is no surviving  
6               spouse or such spouse waives the right to such  
7               funds, to the Medical Retirement Accounts of  
8               the eligible individual’s heirs.

9               “(3) DIVORCE.—The Medical Retirement Ac-  
10       count Board shall issue regulations which provide  
11       that, in the case of an eligible individual with a Med-  
12       ical Retirement Account who becomes divorced after  
13       at least 10 years of marriage to the same spouse,  
14       contributions to the Account during the marriage  
15       and earnings on the Account during the marriage  
16       shall be divided evenly between the Account of such  
17       individual and a Medical Retirement Account of  
18       such individual’s former spouse.

19   **“SEC. 253. MEDICAL RETIREMENT ACCOUNT BOARD.**

20       “(a) IN GENERAL.—There shall be established and  
21       maintained in the Social Security Administration a Med-  
22       ical Retirement Account Board in the same manner as the  
23       Federal Retirement Thrift Investment Board under sub-  
24       chapter VII of chapter 84 of title 5, United States Code.

1       “(b) EXECUTIVE DIRECTOR.—The Medical Retire-  
 2       ment Account Board shall appoint an Executive Director  
 3       in the same manner and with the same functions as the  
 4       Executive Director of the Thrift Savings Board under sec-  
 5       tion 8474 of title 5, United States Code.”.

6       (b) TAX TREATMENT OF CERTAIN CONTRIBUTIONS  
 7       TO MEDICAL RETIREMENT ACCOUNTS.—

8               (1) IN GENERAL.—Part III of subchapter B of  
 9       chapter 1 of the Internal Revenue Code of 1986, as  
 10       amended by this Act, is amended by inserting after  
 11       section 139B the following new section:

12       **“SEC. 139C. MEDICAL RETIREMENT ACCOUNT CONTRIBU-**  
 13               **TIONS.**

14       “Gross income shall not include any contribution to  
 15       a Medical Retirement Account specified under section  
 16       252(c) of the Social Security Act or any earnings on such  
 17       contributions.”.

18               (2) CLERICAL AMENDMENT.—The table of sec-  
 19       tion for part III of subchapter B of chapter 1 of  
 20       such Code, as amended by this Act, is amended by  
 21       inserting after the item relating to section 139B the  
 22       following new item:

“Sec. 139C. Medical Retirement Account contributions.”.

23       (c) CONFORMING AMENDMENTS TO THE MEDICARE  
 24       PROGRAM.—

1           (1) PART A ENTITLEMENT.—Section 1811 of  
2           the Social Security Act (42 U.S.C. 1395d) is amend-  
3           ed by adding at the end the following new sentence:  
4           “On and after the effective date of part B of title  
5           II, the entitlement under the preceding sentence  
6           shall only apply to an individual who is not an eligi-  
7           ble individual (as defined in section 252(a)(2)).”.

8           (2) PART A TRUST FUND.—The third sentence  
9           of section 1817 of the Social Security Act (42  
10          U.S.C. 1395i) is amended in each of paragraphs (1)  
11          and (2) by inserting “subject to section  
12          251(a)(2)(A),” before “the taxes imposed”.

13          (3) PART B ELIGIBILITY.—Section 1836 of the  
14          Social Security Act (42 U.S.C. 1395o) is amended  
15          by adding at the end the following new sentence:  
16          “On and after the effective date of part B of title  
17          II, the eligibility under the preceding sentence shall  
18          only apply to an individual who is not an eligible in-  
19          dividual (as defined in section 252(a)(2)).”.

20          (d) EFFECTIVE DATES.—

21               (1) IN GENERAL.—Except as provided in para-  
22               graph (2), the amendments made by this section  
23               shall take effect on January 1, 2009.

1 (2) INTERNAL REVENUE CODE.—The amend-  
 2 ments made by subsection (b) shall apply to taxable  
 3 years beginning after December 31, 2008.

4 **TITLE V—KEEPING MEDICAID**  
 5 **ON MISSION**

6 **SEC. 501. RESTRUCTURING OF MEDICAID FUNDING.**

7 Title XIX of the Social Security Act (42 U.S.C. 1396  
 8 et seq.) is amended—

9 (1) by redesignating section 1939 as section  
 10 1940; and

11 (2) by inserting after section 1938, the fol-  
 12 lowing:

13 “MEDICAID MODERNIZED AND ON MISSION

14 “SEC. 1939. (a) STATE MEDICAID ASSISTANCE AL-  
 15 LOTMENTS.—Notwithstanding any other provision of this  
 16 title, beginning with fiscal year 2010, and for each fiscal  
 17 year thereafter—

18 “(1) no State shall receive a payment under  
 19 section 1903(a); and

20 “(2) only in the case of a State with a State  
 21 plan under this title that satisfies the conditions de-  
 22 scribed in subsection (c), the Secretary shall pay  
 23 such State the State Medicaid assistance allotment  
 24 for the State determined under subsection (b).

25 “(b) DETERMINATION OF AMOUNT OF ALLOT-  
 26 MENTS.—

1           “(1) IN GENERAL.—Subject to paragraphs (4)  
 2           and (5), the State Medicaid assistance allotment  
 3           payable to a State (other than a State referred to  
 4           in subparagraph (B)(ii)) for a fiscal year shall be  
 5           the amount that bears the same ratio to the amount  
 6           appropriated under subsection (f) for the fiscal year  
 7           (reduced by the amount of the allotments made  
 8           under paragraph (2)), as the ratio of—

9                   “(A) the sum of—

10                       “(i) the population of the State;

11                       “(ii) the number of individuals resid-  
 12                       ing in the State whose family income does  
 13                       not exceed the poverty line (as defined in  
 14                       section 2110(c)(5) applicable to a family of  
 15                       the size involved);

16                       “(iii) the number of individuals resid-  
 17                       ing in the State who are full-benefit dual  
 18                       eligible individuals (as defined in section  
 19                       1935(c)(6)); and

20                       “(iv) the number of disabled individ-  
 21                       uals residing in the State; to

22                       “(B) the sum of the amounts determined  
 23                       under subparagraph (A).

24           “(2) ALLOTMENTS TO TERRITORIES.—

1           “(A) IN GENERAL.—Subject to paragraphs  
 2           (4) and (5), the State Medicaid assistance allot-  
 3           ment payable to a commonwealth or territory  
 4           referred to in subparagraph (B) for a fiscal  
 5           year shall be the amount that bears the same  
 6           ratio to 0.25 percent of the amount appro-  
 7           priated under subsection (f) for the fiscal year,  
 8           as the percentage specified in subparagraph  
 9           (B)) for the commonwealth or territory bears to  
 10          the sum of such percentages for all such com-  
 11          monwealths and territories so described.

12           “(B) PERCENTAGE.—The percentage spec-  
 13          ified in this subparagraph for—

14                   “(i) Puerto Rico is 91.6 percent,

15                   “(ii) Guam is 3.5 percent,

16                   “(iii) the Virgin Islands is 2.6 per-  
 17          cent,

18                   “(iv) American Samoa is 1.2 percent,

19                   and

20                   “(v) the Northern Mariana Islands is  
 21          1.1 percent.

22           “(3) DETERMINATION OF POPULATION AND  
 23          NUMBER OF INDIVIDUALS.—The Secretary shall de-  
 24          termine the State populations and numbers of indi-  
 25          viduals described in paragraph (1) on the basis of

1 the most recent American Community Survey of the  
 2 Bureau of the Census (or, until such data is avail-  
 3 able, on the basis of the 3 most recent Annual Social  
 4 and Economic Supplements of the Current Popu-  
 5 lation Survey of the Bureau of the Census) and such  
 6 other data as the Secretary determines is necessary.

7 “(4) PHASE-IN; TRANSITION ASSISTANCE.—

8 “(A) PHASED-IN CHANGE IN FUNDING  
 9 AMOUNTS.—Notwithstanding paragraph (1) and  
 10 (2), subject to subparagraph (B), the State  
 11 Medicaid assistance allotment determined for a  
 12 State for each of fiscal years 2010 through  
 13 2013 shall be the amount equal to the fol-  
 14 lowing:

15 “(i) FISCAL YEAR 2010.—In the case  
 16 of fiscal year 2010, the amount equal to  
 17 the sum of—

18 “(I) 80 percent of the amount  
 19 paid to the State under section  
 20 1903(a) for fiscal year 2006; and

21 “(II) 20 percent of the amount of  
 22 the State Medicaid assistance allot-  
 23 ment that would be paid to the State  
 24 under paragraph (1) or (2) (as appli-



1 cable) without regard to this para-  
2 graph.

3 “(ii) FISCAL YEAR 2011.—In the case  
4 of fiscal year 2011, the amount equal to  
5 the sum of—

6 “(I) 60 percent of the amount  
7 paid to the State under section  
8 1903(a) for fiscal year 2006; and

9 “(II) 40 percent of the amount of  
10 the State Medicaid assistance allot-  
11 ment that would be paid to the State  
12 under paragraph (1) or (2) (as appli-  
13 cable) without regard to this para-  
14 graph.

15 “(iii) FISCAL YEAR 2012.—In the case  
16 of fiscal year 2012, the amount equal to  
17 the sum of—

18 “(I) 40 percent of the amount  
19 paid to the State under section  
20 1903(a) for fiscal year 2006; and

21 “(II) 60 percent of the amount of  
22 the State Medicaid assistance allot-  
23 ment that would be paid to the State  
24 under paragraph (1) or (2) (as appli-

1 cable) without regard to this para-  
 2 graph.

3 “(iv) FISCAL YEAR 2013.—In the case  
 4 of fiscal year 2013, the amount equal to  
 5 the sum of—

6 “(I) 20 percent of the amount  
 7 paid to the State under section  
 8 1903(a) for fiscal year 2006; and

9 “(II) 80 percent of the amount of  
 10 the State Medicaid assistance allot-  
 11 ment that would be paid to the State  
 12 under paragraph (1) or (2) (as appli-  
 13 cable) without regard to this para-  
 14 graph.

15 “(B) TRANSITION ASSISTANCE.—The  
 16 State Medicaid assistance allotment paid to a  
 17 State for any of fiscal years 2010 through 2014  
 18 shall not be less than the approximate total  
 19 amount paid to the State under section 1903(a)  
 20 for fiscal year 2006.

21 “(c) CONDITIONS DESCRIBED.—For purposes of sub-  
 22 section (a), the conditions described in this subsection are  
 23 the following:

24 “(1) POPULATIONS COVERED.—

1           “(A) IN GENERAL.—Subject to subpara-  
 2 graph (B), the State uses its State Medicaid as-  
 3 sistance allotment to provide medical assistance  
 4 (subject, notwithstanding section 1916 or  
 5 1916A, to payment of premiums or other cost-  
 6 sharing charges (set on a sliding scale based on  
 7 income) that the State may determine) only for  
 8 populations of individuals—

9           “(i) who are eligible for medical as-  
 10 sistance under the State plan on January  
 11 1, 2008; or

12           “(ii) whose family income does not ex-  
 13 ceed 133 percent of the poverty line (as de-  
 14 fined in section 2110(c)(5)).

15           “(B) PRIORITY FOR MANDATORY POPU-  
 16 LATIONS.—In determining the populations eligi-  
 17 ble for medical assistance under the State plan  
 18 in accordance with subparagraph (A), the State  
 19 shall give priority to making populations de-  
 20 scribed in section 1902(a)(10)(A)(i) eligible for  
 21 such assistance.

22           “(C) OPTION TO RISK-ADJUST PRE-  
 23 MIUMS.—With respect to populations covered in  
 24 accordance with this paragraph, a State may

1 impose risk-adjusted premiums based on chron-  
2 ic disease conditions.

3 “(2) BENEFITS.—

4 “(A) IN GENERAL.—The State does not  
5 provide medical assistance for purposes of any  
6 item or service that is not described in section  
7 1905(a) as in effect on January 1, 2008 or au-  
8 thorized to be provided by any State under a  
9 waiver approved under section 1115, 1915, or  
10 otherwise, as in effect on January 1, 2008.

11 “(B) HEALTH PROMOTION AND DISEASE  
12 PREVENTION.—At State option, the State im-  
13 plements initiatives designed to educate the  
14 population of the State with respect to health  
15 promotion and disease prevention of the top 3  
16 lethal diseases for the State.

17 “(3) MATCHING REQUIREMENT.—The State  
18 provides non-Federal matching funds of not less  
19 than \$1 for every \$3 of Federal funds received  
20 under this section.

21 “(4) LIMITATION ON ADMINISTRATIVE EXPEND-  
22 ITURES.—The total amount of reasonable costs in-  
23 curred by the State to administer the State plan for  
24 a fiscal year shall not exceed the amount equal to  
25 3 percent of the State Medicaid assistance allotment

1       paid to the State under this section for such fiscal  
2       year.

3               “(5) APPLICATION OF RESTRICTIONS ON USE  
4       OF FUNDS.—The restrictions on the use of Federal  
5       funds appropriated to carry out this title contained  
6       in title V of division F of the Consolidated Appro-  
7       priations Act, 2005, shall apply to the State Med-  
8       icaid assistance allotments paid to States under this  
9       section for fiscal year 2010 and each fiscal year  
10      thereafter in the same manner as such restrictions  
11      apply to amounts appropriated under division F of  
12      such Act.

13              “(6) PROMOTION OF PRICE AND QUALITY  
14      TRANSPARENCY IN THE PRIVATE MARKET.—The  
15      State provides an assurance that the State has im-  
16      plemented initiatives—

17                      “(A) to promote price and quality trans-  
18                      parency with respect to each type of health in-  
19                      surance offered by health insurance issuers in  
20                      the State; and

21                      “(B) to ensure that any provider of a  
22                      health care item or service that is paid for (in  
23                      whole or in part) with Federal or State funds  
24                      publishes price information with respect to such

1 item or service and makes the information read-  
 2 ily available to consumers.

3 “(7) ANNUAL REPORT ON HEALTH COV-  
 4 ERAGE.—The State submits annual reports to the  
 5 Secretary that—

6 “(A) describe the State’s expenditure of  
 7 the State Medicaid assistance allotment;

8 “(B) include—

9 “(i) the number of individuals pro-  
 10 vided medical assistance through such al-  
 11 lotment;

12 “(ii) the average per beneficiary  
 13 spending of the allotment with respect to—

14 “(I) acute care; and

15 “(II) long-term care; and

16 “(C) the number of individuals in the  
 17 State who are enrolled in private health cov-  
 18 erage.

19 “(d) OPTION TO SUBSIDIZE PURCHASE OF PRIVATE  
 20 MARKET COVERAGE.—

21 “(1) IN GENERAL.—Subject to paragraph (4), a  
 22 State may elect to permit individuals eligible for  
 23 medical assistance in accordance with subsection  
 24 (c)(1) to opt-out of enrollment under the State plan  
 25 (on a risk-adjusted basis) in return for payment on

1 the individual's behalf of the individual health insur-  
 2 ance purchase subsidy amount determined under  
 3 paragraph (2) to an issuer of health insurance cov-  
 4 erage within the private market.

5 “(2) INDIVIDUAL HEALTH INSURANCE PUR-  
 6 CHASE SUBSIDY.—For purposes of paragraph (1),  
 7 the individual health insurance purchase subsidy  
 8 amount determined under this paragraph is equal to  
 9 the actuarial average cost of providing coverage  
 10 under the State plan under this title to all enrollees  
 11 in such plan.

12 “(3) AUTHORITY TO COMBINE SUBSIDY WITH  
 13 REFUNDABLE CREDIT FOR HEALTH INSURANCE COV-  
 14 ERAGE.—Payment of an individual health insurance  
 15 purchase subsidy on behalf of an individual under  
 16 this subsection shall not be taken into account for  
 17 purposes of determining the amount the individual is  
 18 allowed as a credit under section 36 of the Internal  
 19 Revenue Code of 1986 for qualified health insur-  
 20 ance.

21 “(4) ENROLLMENT INFORMATION AND ASSIST-  
 22 ANCE.—A State may only make the election de-  
 23 scribed in paragraph (1) if the State—

24 “(A) makes available to the individuals de-  
 25 scribed in paragraph (1) benefit enrollment

1           counselors to assist the individuals with select-  
2           ing coverage within the individual market; and

3           “(B) has implemented procedures to en-  
4           sure that accurate and complete plan informa-  
5           tion is provided to such individuals prior to  
6           their enrollment in a plan within such market.

7           “(5) FACILITATION OF USE OF FEDERAL TAX  
8           CREDIT TO ELECT CATASTROPHIC OR OTHER PRI-  
9           VATE MARKET COVERAGE.—A State may establish  
10          mechanisms to facilitate the enrollment of individ-  
11          uals who elect to opt-out of the State plan in private  
12          health insurance or in qualified health insurance for  
13          purposes of such individuals being allowed a credit  
14          under section 36 of the Internal Revenue Code of  
15          1986.

16          “(e) AVAILABILITY.—Amounts paid to a State under  
17          this section shall remain available for expenditure without  
18          fiscal year limitation.

19          “(f) APPROPRIATIONS.—

20                 “(1) IN GENERAL.—Out of any money in the  
21          Treasury of the United States not otherwise appro-  
22          priated, there are appropriated for making State  
23          Medicaid assistance allotments to States under this  
24          section—



1           “(A)     for     fiscal     year     2010,  
2           \$212,000,000,000; and

3           “(B) for each of fiscal years 2011 through  
4           2017, the amount appropriated under this sub-  
5           section for the preceding fiscal year, increased  
6           by the percentage increase (if any) in the chain-  
7           weighted consumer price index for all urban  
8           consumers (all items; United States city aver-  
9           age) for the previous fiscal year.

10          “(2) ADDITIONAL APPROPRIATION FOR TRANSI-  
11          TION YEARS; HOLD HARMLESS.—Out of any money  
12          in the Treasury of the United States not otherwise  
13          appropriated, there are appropriated for the period  
14          of fiscal years 2010 through 2014, \$20,000,000,000,  
15          for purposes of carrying out subsection (b)(4)(B).”.

16 **SEC. 502. MEDICAID ADVANTAGE PROGRAM.**

17          Title XIX of the Social Security Act (42 U.S.C. 1396  
18          et seq.), as amended by section 501, is amended by—

19               (1) redesignating section 1940 as section 1941;  
20          and

21               (2) inserting after section 1939 the following  
22          new section:

23               “MEDICAID ADVANTAGE PROGRAM

24          “SEC. 1940. (a) DEFINITIONS.—In this section:

1 “(1) MEDICAID ADVANTAGE ELIGIBLE INDIVIDUAL.—The term ‘Medicaid Advantage eligible individual’ means an individual who—

4 “(A) is a full-benefit dual eligible individual (as defined in section 1935(c)(6)); and

6 “(B) resides in a participating State.

7 “(2) PARTICIPATING STATE.—The term ‘participating State’ means a State that elects to offer  
8 a State Medicaid Advantage program under this section.  
10

11 “(3) PROGRAM.—The term ‘program’ means a  
12 State Medicaid Advantage program.

13 “(4) STATE MEDICAID ADVANTAGE PROGRAM.—  
14 The term ‘State Medicaid Advantage program’  
15 means a program offered by a State that provides  
16 individuals enrolled in the program a medical home  
17 where they receive a seamless continuum of medical  
18 care and care management that meets the following  
19 requirements:

20 “(A) OPERATION.—The primary manager  
21 of the program is the State.

22 “(B) INTEGRATED COVERAGE.—The program provides integrated health care benefits to  
23 Medicaid Advantage eligible individuals.  
24

25 “(b) ESTABLISHMENT.—

1           “(1) IN GENERAL.—Beginning with fiscal year  
2           2010, a State may elect to provide benefits to Med-  
3           icaid Advantage eligible individuals who elect to en-  
4           roll in a program established under this section.  
5           Such benefits shall be provided instead of benefits  
6           under title XVIII or under a State plan under this  
7           title.

8           “(2) ENROLLMENT.—

9                   “(A) IN GENERAL.—A participating State  
10           shall establish procedures to enroll Medicaid  
11           Advantage eligible individuals in the program.  
12           Such procedures shall ensure that a Medicaid  
13           Advantage eligible individual may elect to not  
14           enroll and to disenroll upon request from the  
15           program.

16                   “(B) PRESERVATION OF ORIGINAL MEDI-  
17           CARE AND MEDICAID BENEFITS.—Nothing in  
18           this section shall be construed to limit the right  
19           of a Medicaid Advantage eligible individual who  
20           is entitled to benefits under title XVIII or  
21           under a State plan under this title to receive  
22           such benefits if the individual elects to not en-  
23           roll or to disenroll from the program.

24           “(3) PAYMENTS.—

1           “(A) IN GENERAL.—The Secretary shall  
 2           develop a system for making risk-adjusted pay-  
 3           ments on a capitated basis to participating  
 4           States for the cost of providing items and serv-  
 5           ices to each individual enrolled in the program  
 6           that would, but for the application of this sec-  
 7           tion, be covered under—

8                   “(i) title XVIII, including the cost of  
 9                   providing qualified prescription drug cov-  
 10                  erage under part D of such title; or

11                  “(ii) a State plan under this title.

12           “(B) DETERMINATION OF PAYMENT  
 13           AMOUNT.—The Secretary shall use actuarial  
 14           data and payment history in determining the  
 15           payment amount under such system with re-  
 16           spect to each individual enrolled in the pro-  
 17           gram, and shall adjust the payment amount to  
 18           take into account the comparative frailty of  
 19           such individuals and such other factors as the  
 20           Secretary determines to be appropriate.

21           “(C) UPDATE OF PAYMENT SYSTEM.—The  
 22           Secretary shall update the payment system de-  
 23           veloped under this paragraph as appropriate.

24           “(D) STATE PROCEDURES.—A partici-  
 25           pating State shall establish such procedures for

1 the submission of claims and the transmission  
 2 of data as the Secretary determines appropriate  
 3 in order to carry out the payment system devel-  
 4 oped under this paragraph.

5 “(4) SCOPE OF BENEFITS.—A participating  
 6 State shall provide individuals enrolled in the pro-  
 7 gram, regardless of the source of payment and di-  
 8 rectly or under contracts with other entities, at a  
 9 minimum—

10 “(A) all items and services covered under  
 11 title XVIII and all items and services covered  
 12 under this title, except that States shall have  
 13 authority and flexibility to design benefit pack-  
 14 ages that meet the specific needs of Medicaid  
 15 Advantage eligible individuals, including the  
 16 needs of such individuals with mental illness;

17 “(B) qualified prescription drug coverage  
 18 (as defined in section 1860D–2(a)(1)); and

19 “(C) such other items and services as the  
 20 State determines appropriate.

21 “(c) RESPONSIBILITIES OF PARTICIPATING  
 22 STATES.—

23 “(1) BIDDING PROCESS FOR HEALTH PLANS.—

24 “(A) IN GENERAL.—A participating State  
 25 shall establish procedures for health plans to

1 participate in a bidding process to enter into a  
 2 contract under paragraph (2) to provide serv-  
 3 ices to Medicaid Advantage eligible individuals  
 4 under the program.

5 “(B) BID SUBMISSION.—Each health plan  
 6 participating in the bidding process established  
 7 under paragraph (1) shall submit a bid rep-  
 8 resenting the estimated cost to such plans of  
 9 providing Medicaid Advantage eligible individ-  
 10 uals the benefits described in subsection (b)(4).

11 “(2) CONTRACTS WITH HEALTH PLANS.—

12 “(A) IN GENERAL.—A participating State  
 13 shall enter into contracts with health plans, in-  
 14 cluding managed care health plans, in order to  
 15 provide integrated health care benefits to Med-  
 16 icaid Advantage eligible individuals enrolled in  
 17 the program.

18 “(B) RESPONSIBILITY FOR PROVIDING  
 19 CARE.—Each contract entered into under this  
 20 paragraph shall provide that the health plan is  
 21 responsible for—

22 “(i) providing the benefits described  
 23 in subsection (b)(4) to individuals enrolled  
 24 in the program;

1 “(ii) collecting performance data on  
 2 treatments and outcomes for each such in-  
 3 dividual; and

4 “(iii) providing such data to the State  
 5 for use in monitoring the program under  
 6 this section.

7 “(C) ENSURING QUALITY AND VALUE.—

8 “(i) PROMOTING COMPETITION.—A  
 9 participating State shall provide incentives  
 10 for health plans to compete with respect to  
 11 the quality and value of the services pro-  
 12 vided to Medicaid Advantage eligible indi-  
 13 viduals who are enrolled in the program.

14 “(ii) REWARDING EFFICIENCY.—A  
 15 participating State may reward health  
 16 plans that provide higher quality care at a  
 17 reduced price under the program.

18 “(3) CHOICE OF PLANS.—A participating State  
 19 shall establish procedures to allow Medicaid Advan-  
 20 tage eligible individuals to choose from among the  
 21 competing plans that the State enters into a con-  
 22 tract with under paragraph (2).

23 “(4) PAYMENT PROCEDURES.—A participating  
 24 State shall establish procedures with respect to pay-  
 25 ments in accordance with subsection (b)(3)(D).

1           “(5) MONITORING AND ENFORCEMENT.—A  
 2       participating State shall share responsibility with the  
 3       Secretary for—

4           “(A) carefully monitoring health plans that  
 5       the State enters into a contract with under  
 6       paragraph (2); and

7           “(B) bringing action against those health  
 8       plans that do not meet their obligations under  
 9       such contracts.

10       “(d) FEDERAL RESPONSIBILITIES.—

11       “(1) PAYMENTS TO PARTICIPATING STATES.—  
 12       The Secretary shall provide for payments to partici-  
 13       pating States in accordance with subsection (b)(3).

14       “(2) MONITORING AND ENFORCEMENT.—

15       “(A) GOALS.—The Secretary shall set and  
 16       monitor goals for programs.

17       “(B) MONITORING AND ENFORCEMENT.—  
 18       The Secretary shall share responsibility with a  
 19       participating State for—

20           “(i) carefully monitoring health plans  
 21       that the State enters into a contract with  
 22       under subsection (c)(2); and

23           “(ii) bringing appropriate action  
 24       against those health plans that do not



1           meet their obligations under such con-  
2           tracts.

3           “(3) ACCESS TO PRESCRIPTION DRUG DATA.—

4           “(A) IN GENERAL.—Notwithstanding any  
5           provision of law, the Secretary shall ensure that  
6           States have access to prescription drug data  
7           submitted by prescription drug plans and MA-  
8           PD plans under part D of title XVIII for the  
9           purpose of carrying out the program under this  
10          section.

11          “(B) SAFEGUARDS.—The Secretary shall  
12          ensure that States have in place appropriate  
13          safeguards to protect against the unauthorized  
14          disclosure of data provided under subparagraph  
15          (A).

16          “(e) WAIVERS OF REQUIREMENTS .—With respect to  
17          carrying out a State Medicaid Advantage program under  
18          this section, the following requirements of this title (and  
19          regulations relating to such requirements) shall not apply:

20               “(1) Section 1902(a)(1), relating to any re-  
21               quirement that a program or benefits under such a  
22               program be provided in all areas of a State.

23               “(2) Section 1902(a)(10), insofar as such sec-  
24               tion relates to comparability of services among dif-  
25               ferent population groups.

1           “(3) Sections 1902(a)(23) and 1915(b)(4), re-  
 2           lating to freedom of choice of providers under a pro-  
 3           gram.

4           “(4) Section 1903(m)(2)(A), insofar as it re-  
 5           stricts a program from receiving prepaid capitation  
 6           payments.

7           “(5) Such other provisions of this title that the  
 8           Secretary determines are inapplicable to carrying out  
 9           a program under this section.”.

10 **SEC. 503. HIGH PERFORMANCE BONUSES.**

11           Section 1939 of the Social Security Act, as added by  
 12           section 501, is amended by adding at the end the fol-  
 13           lowing:

14           “(g) BONUS TO REWARD HIGH PERFORMANCE  
 15           STATES.—

16           “(1) IN GENERAL.—In addition to the State  
 17           Medicaid assistance allotments paid to States in ac-  
 18           cordance with the preceding provisions of this sec-  
 19           tion, the Secretary shall make a payment pursuant  
 20           to this subsection to each State for each bonus year  
 21           for which the State is a high performing State.

22           “(2) AMOUNT OF PAYMENT.—

23           “(A) IN GENERAL.—Subject to subpara-  
 24           graph (B), the Secretary shall determine the

1 amount of the payment under this subsection to  
 2 a high performing State for a bonus year.

3 “(B) LIMITATION.—The amount payable  
 4 to a State under this subsection for a bonus  
 5 year shall not exceed 5 percent of the State  
 6 Medicaid assistance allotment paid to the State  
 7 under subsection (a).

8 “(3) USE OF FUNDS.—Amounts paid to a State  
 9 under this subsection shall be used to facilitate the  
 10 enrollment of uninsured individuals who reside in  
 11 the State in private health insurance or to maintain  
 12 the enrollment of individuals in such health insur-  
 13 ance.

14 “(4) DEFINITIONS.—As used in this paragraph:

15 “(A) BONUS YEAR.—The term ‘bonus  
 16 year’ means each of fiscal years 2010 through  
 17 2017.

18 “(B) HIGH PERFORMING STATE.—The  
 19 term ‘high performing State’ means, with re-  
 20 spect to a bonus year, a State that—

21 “(i) with respect to, each of bonus  
 22 years 2010 and 2011, the Secretary deter-  
 23 mines that at least 90 percent of the total  
 24 population of the State is enrolled in pri-  
 25 vate health insurance coverage; and

1 “(ii) with respect to each of bonus  
 2 years 2012 through 2017, the Secretary  
 3 determines that—

4 “(I) at least 95 percent of the  
 5 total population of the State is en-  
 6 rolled in private health insurance cov-  
 7 erage; and

8 “(II) the State has satisfies the  
 9 conditions in subsection (c).

10 “(5) APPROPRIATION.—Out of any money in  
 11 the Treasury of the United States not otherwise ap-  
 12 propriated, there are appropriated for the period of  
 13 fiscal years 2010 through 2017, \$5,000,000,000 for  
 14 making payments under this subsection.”.

## 15 **TITLE VI—ADMINISTRATIVE** 16 **HEALTH CARE TRIBUNALS**

### 17 **SEC. 601. STATE GRANTS TO CREATE ADMINISTRATIVE** 18 **HEALTH CARE TRIBUNALS.**

19 Part P of title III of the Public Health Service Act  
 20 (42 U.S.C. 280g et seq.) is amended by adding at the end  
 21 the following:

### 22 **“SEC. 399R. STATE GRANTS TO CREATE ADMINISTRATIVE** 23 **HEALTH CARE TRIBUNALS.**

24 “(a) IN GENERAL.—The Secretary may award grants  
 25 to States for the development, implementation, and eval-

1 uation of administrative health care tribunals that comply  
2 with this section, for the resolution of disputes concerning  
3 injuries allegedly caused by health care providers.

4 “(b) CONDITIONS FOR DEMONSTRATION GRANTS.—  
5 To be eligible to receive a grant under this section, a State  
6 shall submit to the Secretary an application at such time,  
7 in such manner, and containing such information as may  
8 be required by the Secretary. A grant shall be awarded  
9 under this section on such terms and conditions as the  
10 Secretary determines appropriate.

11 “(c) REPRESENTATION BY COUNSEL.—A State that  
12 receives a grant under this section may not preclude any  
13 party to a dispute before an administrative health care tri-  
14 bunal operated under such grant from obtaining legal rep-  
15 resentation during any review by the expert panel under  
16 subsection (d), the administrative health care tribunal  
17 under subsection (e), or a State court under subsection  
18 (f).

19 “(d) EXPERT PANEL REVIEW AND EARLY OFFER  
20 GUIDELINES.—

21 “(1) IN GENERAL.—Prior to the submission of  
22 any dispute concerning injuries allegedly caused by  
23 health care providers to an administrative health  
24 care tribunal under this section, such allegations  
25 shall first be reviewed by an expert panel.

1 “(2) COMPOSITION.—

2 “(A) IN GENERAL.—An expert panel under  
3 this subsection shall be composed of 3 medical  
4 experts (either physicians or health care profes-  
5 sionals) and 3 attorneys to be appointed by the  
6 head of the State agency responsible for health.

7 “(B) LICENSURE AND EXPERTISE.—Each  
8 physician or health care professional appointed  
9 to an expert panel under subparagraph (A)  
10 shall—

11 “(i) be appropriately credentialed or  
12 licensed in 1 or more States to deliver  
13 health care services; and

14 “(ii) typically treat the condition,  
15 make the diagnosis, or provide the type of  
16 treatment that is under review.

17 “(C) INDEPENDENCE.—

18 “(i) IN GENERAL.—Subject to clause  
19 (ii), each individual appointed to an expert  
20 panel under this paragraph shall—

21 “(I) not have a material familial,  
22 financial, or professional relationship  
23 with a party involved in the dispute  
24 reviewed by the panel; and

1 “(II) not otherwise have a con-  
2 flict of interest with such a party.

3 “(ii) EXCEPTION.—Nothing in clause  
4 (i) shall be construed to prohibit an indi-  
5 vidual who has staff privileges at an insti-  
6 tution where the treatment involved in the  
7 dispute was provided from serving as a  
8 member of an expert panel merely on the  
9 basis of such affiliation, if the affiliation is  
10 disclosed to the parties and neither party  
11 objects.

12 “(D) PRACTICING HEALTH CARE PROFES-  
13 SIONAL IN SAME FIELD.—

14 “(i) IN GENERAL.—In a dispute be-  
15 fore an expert panel that involves treat-  
16 ment, or the provision of items or serv-  
17 ices—

18 “(I) by a physician, the medical  
19 experts on the expert panel shall be  
20 practicing physicians (allopathic or os-  
21 teopathic) of the same or similar spe-  
22 cialty as a physician who typically  
23 treats the condition, makes the diag-  
24 nosis, or provides the type of treat-  
25 ment under review; or

1                   “(II) by a health care profes-  
2                   sional other than a physician, at least  
3                   two medical experts on the expert  
4                   panel shall be practicing physicians  
5                   (allopathic or osteopathic) of the same  
6                   or similar specialty as the health care  
7                   professional who typically treats the  
8                   condition, makes the diagnosis, or  
9                   provides the type of treatment under  
10                  review, and, if determined appropriate  
11                  by the State agency, the third medical  
12                  expert shall be a practicing health  
13                  care professional (other than such a  
14                  physician) of such a same or similar  
15                  specialty.

16                  “(ii) PRACTICING DEFINED.—In this  
17                  paragraph, the term ‘practicing’ means,  
18                  with respect to an individual who is a phy-  
19                  sician or other health care professional,  
20                  that the individual provides health care  
21                  services to individual patients on average  
22                  at least 2 days a week.

23                  “(E) PEDIATRIC EXPERTISE.—In the case  
24                  of dispute relating to a child, at least 1 medical



1 expert on the expert panel shall have expertise  
2 described in subparagraph (D)(i) in pediatrics.

3 “(3) DETERMINATION.—After a review under  
4 paragraph (1), an expert panel shall make a deter-  
5 mination as to the liability of the parties involved  
6 and compensation.

7 “(4) ACCEPTANCE.—If the parties to a dispute  
8 before an expert panel under this subsection accept  
9 the determination of the expert panel concerning li-  
10 ability and compensation, such compensation shall  
11 be paid to the claimant and the claimant shall agree  
12 to forgo any further action against the health care  
13 providers involved.

14 “(5) FAILURE TO ACCEPT.—If any party de-  
15 cides not to accept the expert panel’s determination,  
16 the matter shall be referred to an administrative  
17 health care tribunal created pursuant to this section.

18 “(e) ADMINISTRATIVE HEALTH CARE TRIBUNALS.—

19 “(1) IN GENERAL.—Upon the failure of any  
20 party to accept the determination of an expert panel  
21 under subsection (d), the parties shall have the right  
22 to request a hearing concerning the liability or com-  
23 pensation involved by an administrative health care  
24 tribunal established by the State involved.

1           “(2) REQUIREMENTS.—In establishing an ad-  
2       ministrative health care tribunal under this section,  
3       a State shall—

4           “(A) ensure that such tribunals are pre-  
5       sided over by special judges with health care ex-  
6       pertise;

7           “(B) provide authority to such judges to  
8       make binding rulings, rendered in written deci-  
9       sions, on standards of care, causation, com-  
10      pensation, and related issues with reliance on  
11      independent expert witnesses commissioned by  
12      the tribunal;

13          “(C) establish negligence as the legal  
14      standard for the tribunal;

15          “(D) allow the admission into evidence of  
16      the recommendation made by the expert panel  
17      under subsection (d); and

18          “(E) provide for an appeals process to  
19      allow for review of decisions by State courts.

20      “(f) REVIEW BY STATE COURT AFTER EXHAUSTION  
21      OF ADMINISTRATIVE REMEDIES.—

22          “(1) RIGHT TO FILE.—If any party to a dispute  
23      before a health care tribunal under subsection (e) is  
24      not satisfied with the determinations of the tribunal,

1 the party shall have the right to file their claim in  
 2 a State court of competent jurisdiction.

3 “(2) FORFEIT OF AWARDS.—Any party filing  
 4 an action in a State court in accordance with para-  
 5 graph (1) shall forfeit any compensation award  
 6 made under subsection (e).

7 “(3) ADMISSIBILITY.—The determinations of  
 8 the expert panel and the administrative health care  
 9 tribunal pursuant to subsections (d) and (e) with re-  
 10 spect to a State court proceeding under paragraph  
 11 (1) shall be admissible into evidence in any such  
 12 State court proceeding.

13 “(g) DEFINITION.—In this section, the term ‘health  
 14 care provider’ has the meaning given such term for pur-  
 15 poses of part A of title VII.

16 “(h) FUNDING.—

17 “(1) ONE-TIME INCREASE IN MEDICAID PAY-  
 18 MENT.—In the case of a State awarded a grant to  
 19 carry out this section, the total amount of Federal  
 20 payments made to the State under section 1903(a)  
 21 of the Social Security Act or section 1939(b) of such  
 22 Act (in the case of fiscal year 2010 or any fiscal  
 23 year thereafter) for the first fiscal year for which  
 24 such grant is awarded shall be increased by an  
 25 amount equal to 1 percent of the total amount of

1       such payments made to the State for the preceding  
 2       fiscal year under such 1903(a) or 1939(b) (as appli-  
 3       cable) for purposes of carrying out this section.  
 4       Amounts paid to a State pursuant to this subsection  
 5       shall remain available until expended.

6               “(2) AUTHORIZATION OF APPROPRIATIONS.—  
 7       There are authorized to be appropriated for any fis-  
 8       cal year such sums as may be necessary for purposes  
 9       of making payments to States pursuant to para-  
 10      graph (1).”.

11                   **TITLE VII—HEALTH**  
 12       **INFORMATION TECHNOLOGY**  
 13   **Subtitle A—Assisting the Develop-**  
 14       **ment of Health Information**  
 15       **Technology**

16   **SEC. 701. PURPOSE.**

17       It is the purpose of this subtitle to promote the utili-  
 18      zation of health record banking by improving the coordina-  
 19      tion of health information through an infrastructure for  
 20      the secure and authorized exchange and use of healthcare  
 21      information.

22   **SEC. 702. HEALTH RECORD BANKING.**

23       (a) ESTABLISHMENT.—Not later than 1 year after  
 24      the date of enactment of this Act, the Secretary of Health  
 25      and Human Services shall promulgate regulations to pro-

1 vide for the certification and auditing of the banking of  
2 electronic medical records.

3 (b) GENERAL RIGHTS.—An individual who has a  
4 health record contained in a health record bank shall  
5 maintain ownership over the health record and shall have  
6 the right to review the contents of the record.

7 **SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY**  
8 **AND CONFIDENTIALITY STANDARDS.**

9 (a) IN GENERAL.—Current Federal security and con-  
10 fidentiality standards and State security and confiden-  
11 tiality laws shall apply to this subtitle until such time as  
12 Congress acts to amend such standards.

13 (b) DEFINITIONS.—In this section:

14 (1) CURRENT FEDERAL SECURITY AND CON-  
15 FIDENTIALITY STANDARDS.—The term “current  
16 Federal security and confidentiality standards”  
17 means the Federal privacy standards established  
18 pursuant to section 264(c) of the Health Insurance  
19 Portability and Accountability Act of 1996 (42  
20 U.S.C. 1320d–2 note) and security standards estab-  
21 lished under section 1173(d) of the Social Security  
22 Act (42 U.S.C. 1320d–2(d)).

23 (2) STATE SECURITY AND CONFIDENTIALITY  
24 LAWS.—The term “State security and confidentiality  
25 laws” means State laws and regulations relating to

1 the privacy and confidentiality of individually identi-  
 2 fiable health information or to the security of such  
 3 information.

4 (3) STATE.—The term “State” has the mean-  
 5 ing given such term for purposes of title XI of the  
 6 Social Security Act, as provided under section  
 7 1101(a) of such Act (42 U.S.C. 1301(a)).

8 **Subtitle B—Promoting the Use of**  
 9 **Health Information Technology**  
 10 **to Better Coordinate Health**  
 11 **Care**

12 **SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PEN-**  
 13 **ALTIES AND CRIMINAL PENALTIES FOR PRO-**  
 14 **VISION OF HEALTH INFORMATION TECH-**  
 15 **NOLOGY AND TRAINING SERVICES.**

16 (a) FOR CIVIL PENALTIES.—Section 1128A of the  
 17 Social Security Act (42 U.S.C. 1320a–7a) is amended—

18 (1) in subsection (b), by adding at the end the  
 19 following new paragraph:

20 “(4) For purposes of this subsection, inducements to  
 21 reduce or limit services described in paragraph (1) shall  
 22 not include the practical or other advantages resulting  
 23 from health information technology or related installation,  
 24 maintenance, support, or training services.”; and

1           (2) in subsection (i), by adding at the end the  
2 following new paragraph:

3           “(8) The term ‘health information technology’  
4 means hardware, software, license, right, intellectual  
5 property, equipment, or other information tech-  
6 nology (including new versions, upgrades, and  
7 connectivity) designed or provided primarily for the  
8 electronic creation, maintenance, or exchange of  
9 health information to better coordinate care or im-  
10 prove health care quality, efficiency, or research.”.

11       (b) FOR CRIMINAL PENALTIES.—Section 1128B of  
12 such Act (42 U.S.C. 1320a–7b) is amended—

13           (1) in subsection (b)(3)—

14               (A) in subparagraph (G), by striking  
15 “and” at the end;

16               (B) in the subparagraph (H) added by sec-  
17 tion 237(d) of the Medicare Prescription Drug,  
18 Improvement, and Modernization Act of 2003  
19 (Public Law 108–173; 117 Stat. 2213)—

20                   (i) by moving such subparagraph 2  
21 ems to the left; and

22                   (ii) by striking the period at the end  
23 and inserting a semicolon;

24               (C) in the subparagraph (H) added by sec-  
25 tion 431(a) of such Act (117 Stat. 2287)—

1 (i) by redesignating such subpara-  
2 graph as subparagraph (I);

3 (ii) by moving such subparagraph 2  
4 ems to the left; and

5 (iii) by striking the period at the end  
6 and inserting “; and”; and

7 (D) by adding at the end the following new  
8 subparagraph:

9 “(J) any nonmonetary remuneration (in the  
10 form of health information technology, as defined in  
11 section 1128A(i)(8), or related installation, mainte-  
12 nance, support or training services) made to a per-  
13 son by a specified entity (as defined in subsection  
14 (g)) if—

15 “(i) the provision of such remuneration is  
16 without an agreement between the parties or  
17 legal condition that—

18 “(I) limits or restricts the use of the  
19 health information technology to services  
20 provided by the physician to individuals re-  
21 ceiving services at the specified entity;

22 “(II) limits or restricts the use of the  
23 health information technology in conjunc-  
24 tion with other health information tech-  
25 nology; or



1 “(III) conditions the provision of such  
2 remuneration on the referral of patients or  
3 business to the specified entity;

4 “(ii) such remuneration is arranged for in  
5 a written agreement that is signed by the par-  
6 ties involved (or their representatives) and that  
7 specifies the remuneration solicited or received  
8 (or offered or paid) and states that the provi-  
9 sion of such remuneration is made for the pri-  
10 mary purpose of better coordination of care or  
11 improvement of health quality, efficiency, or re-  
12 search; and

13 “(iii) the specified entity providing the re-  
14 muneration (or a representative of such entity)  
15 has not taken any action to disable any basic  
16 feature of any hardware or software component  
17 of such remuneration that would permit inter-  
18 operability.”; and

19 (2) by adding at the end the following new sub-  
20 section:

21 “(g) SPECIFIED ENTITY DEFINED.—For purposes of  
22 subsection (b)(3)(J), the term ‘specified entity’ means an  
23 entity that is a hospital, group practice, prescription drug  
24 plan sponsor, a Medicare Advantage organization, or any  
25 other such entity specified by the Secretary, considering

1 the goals and objectives of this section, as well as the goals  
 2 to better coordinate the delivery of health care and to pro-  
 3 mote the adoption and use of health information tech-  
 4 nology.”.

5 (c) EFFECTIVE DATE AND EFFECT ON STATE  
 6 LAWS.—

7 (1) EFFECTIVE DATE.—The amendments made  
 8 by subsections (a) and (b) shall take effect on the  
 9 date that is 120 days after the date of the enact-  
 10 ment of this Act.

11 (2) PREEMPTION OF STATE LAWS.—No State  
 12 (as defined in section 1101(a) of the Social Security  
 13 Act (42 U.S.C. 1301(a)) for purposes of title XI of  
 14 such Act) shall have in effect a State law that im-  
 15 poses a criminal or civil penalty for a transaction de-  
 16 scribed in section 1128A(b)(4) or section  
 17 1128B(b)(3)(J) of such Act, as added by subsections  
 18 (a)(1) and (b), respectively, if the conditions de-  
 19 scribed in the respective provision, with respect to  
 20 such transaction, are met.

21 (d) STUDY AND REPORT TO ASSESS EFFECT OF  
 22 SAFE HARBORS ON HEALTH SYSTEM.—

23 (1) IN GENERAL.—The Secretary of Health and  
 24 Human Services shall conduct a study to determine  
 25 the impact of each of the safe harbors described in

1 paragraph (3). In particular, the study shall examine  
2 the following:

3 (A) The effectiveness of each safe harbor  
4 in increasing the adoption of health information  
5 technology.

6 (B) The types of health information tech-  
7 nology provided under each safe harbor.

8 (C) The extent to which the financial or  
9 other business relationships between providers  
10 under each safe harbor have changed as a re-  
11 sult of the safe harbor in a way that adversely  
12 affects or benefits the health care system or  
13 choices available to consumers.

14 (D) The impact of the adoption of health  
15 information technology on health care quality,  
16 cost, and access under each safe harbor.

17 (2) REPORT.—Not later than 3 years after the  
18 effective date described in subsection (c)(1), the Sec-  
19 retary of Health and Human Services shall submit  
20 to Congress a report on the study under paragraph  
21 (1).

22 (3) SAFE HARBORS DESCRIBED.—For purposes  
23 of paragraphs (1) and (2), the safe harbors de-  
24 scribed in this paragraph are—

1 (A) the safe harbor under section  
 2 1128A(b)(4) of such Act (42 U.S.C. 1320a–  
 3 7a(b)(4)), as added by subsection (a)(1); and

4 (B) the safe harbor under section  
 5 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–  
 6 7b(b)(3)(J)), as added by subsection (b).

7 **SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PHYSI-**  
 8 **CIAN REFERRALS (UNDER STARK) FOR PRO-**  
 9 **VISION OF HEALTH INFORMATION TECH-**  
 10 **NOLOGY AND TRAINING SERVICES TO**  
 11 **HEALTH CARE PROFESSIONALS.**

12 (a) IN GENERAL.—Section 1877(b) of the Social Se-  
 13 curity Act (42 U.S.C. 1395nn(b)) is amended by adding  
 14 at the end the following new paragraph:

15 “(6) INFORMATION TECHNOLOGY AND TRAIN-  
 16 ING SERVICES.—

17 “(A) IN GENERAL.—Any nonmonetary re-  
 18 munerated (in the form of health information  
 19 technology or related installation, maintenance,  
 20 support or training services) made by a speci-  
 21 fied entity to a physician if—

22 “(i) the provision of such remunera-  
 23 tion is without an agreement between the  
 24 parties or legal condition that—

1 “(I) limits or restricts the use of  
2 the health information technology to  
3 services provided by the physician to  
4 individuals receiving services at the  
5 specified entity;

6 “(II) limits or restricts the use of  
7 the health information technology in  
8 conjunction with other health informa-  
9 tion technology; or

10 “(III) conditions the provision of  
11 such remuneration on the referral of  
12 patients or business to the specified  
13 entity;

14 “(ii) such remuneration is arranged  
15 for in a written agreement that is signed  
16 by the parties involved (or their represent-  
17 atives) and that specifies the remuneration  
18 made and states that the provision of such  
19 remuneration is made for the primary pur-  
20 pose of better coordination of care or im-  
21 provement of health quality, efficiency, or  
22 research; and

23 “(iii) the specified entity (or a rep-  
24 resentative of such entity) has not taken  
25 any action to disable any basic feature of

1           any hardware or software component of  
2           such remuneration that would permit  
3           interoperability.

4           “(B) HEALTH INFORMATION TECHNOLOGY  
5           DEFINED.—For purposes of this paragraph, the  
6           term ‘health information technology’ means  
7           hardware, software, license, right, intellectual  
8           property, equipment, or other information tech-  
9           nology (including new versions, upgrades, and  
10          connectivity) designed or provided primarily for  
11          the electronic creation, maintenance, or ex-  
12          change of health information to better coordi-  
13          nate care or improve health care quality, effi-  
14          ciency, or research.

15          “(C) SPECIFIED ENTITY DEFINED.—For  
16          purposes of this paragraph, the term ‘specified  
17          entity’ means an entity that is a hospital, group  
18          practice, prescription drug plan sponsor, a  
19          Medicare Advantage organization, or any other  
20          such entity specified by the Secretary, consid-  
21          ering the goals and objectives of this section, as  
22          well as the goals to better coordinate the deliv-  
23          ery of health care and to promote the adoption  
24          and use of health information technology.”.

25          (b) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

1           (1) EFFECTIVE DATE.—The amendment made  
2           by subsection (a) shall take effect on the date that  
3           is 120 days after the date of the enactment of this  
4           Act.

5           (2) PREEMPTION OF STATE LAWS.—No State  
6           (as defined in section 1101(a) of the Social Security  
7           Act (42 U.S.C. 1301(a)) for purposes of title XI of  
8           such Act) shall have in effect a State law that im-  
9           poses a criminal or civil penalty for a transaction de-  
10          scribed in section 1877(b)(6) of such Act, as added  
11          by subsection (a), if the conditions described in such  
12          section, with respect to such transaction, are met.

13          (c) STUDY AND REPORT TO ASSESS EFFECT OF EX-  
14          CEPTION ON HEALTH SYSTEM.—

15               (1) IN GENERAL.—The Secretary of Health and  
16          Human Services shall conduct a study to determine  
17          the impact of the exception under section 1877(b)(6)  
18          of such Act (42 U.S.C. 1395nn(b)(6)), as added by  
19          subsection (a). In particular, the study shall examine  
20          the following:

21                   (A) The effectiveness of the exception in  
22                   increasing the adoption of health information  
23                   technology.

24                   (B) The types of health information tech-  
25                   nology provided under the exception.

1 (C) The extent to which the financial or  
 2 other business relationships between providers  
 3 under the exception have changed as a result of  
 4 the exception in a way that adversely affects or  
 5 benefits the health care system or choices avail-  
 6 able to consumers.

7 (D) The impact of the adoption of health  
 8 information technology on health care quality,  
 9 cost, and access under the exception.

10 (2) REPORT.—Not later than 3 years after the  
 11 effective date described in subsection (b)(1), the Sec-  
 12 retary of Health and Human Services shall submit  
 13 to Congress a report on the study under paragraph  
 14 (1).

15 **SEC. 713. RULES OF CONSTRUCTION REGARDING USE OF**  
 16 **CONSORTIA.**

17 (a) APPLICATION TO SAFE HARBOR FROM CRIMINAL  
 18 PENALTIES.—Section 1128B(b)(3) of the Social Security  
 19 Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding  
 20 after and below subparagraph (J), as added by section  
 21 711(b)(1), the following: “For purposes of subparagraph  
 22 (J), nothing in such subparagraph shall be construed as  
 23 preventing a specified entity, consistent with the specific  
 24 requirements of such subparagraph, from forming a con-  
 25 sortium composed of health care providers, payers, em-



1 ployers, and other interested entities to collectively pur-  
 2 chase and donate health information technology, or from  
 3 offering health care providers a choice of health informa-  
 4 tion technology products in order to take into account the  
 5 varying needs of such providers receiving such products.”.

6 (b) APPLICATION TO STARK EXCEPTION.—Para-  
 7 graph (6) of section 1877(b) of the Social Security Act  
 8 (42 U.S.C. 1395nn(b)), as added by section 712(a), is  
 9 amended by adding at the end the following new subpara-  
 10 graph:

11 “(D) RULE OF CONSTRUCTION.—For pur-  
 12 poses of subparagraph (A), nothing in such  
 13 subparagraph shall be construed as preventing  
 14 a specified entity, consistent with the specific  
 15 requirements of such subparagraph, from—

16 “(i) forming a consortium composed  
 17 of health care providers, payers, employers,  
 18 and other interested entities to collectively  
 19 purchase and donate health information  
 20 technology; or

21 “(ii) offering health care providers a  
 22 choice of health information technology  
 23 products in order to take into account the  
 24 varying needs of such providers receiving  
 25 such products.”.

# 1      **TITLE VIII—MISCELLANEOUS**

## 2      **SEC. 801. DEDICATION OF MEDICAID AND REVENUE SAV-** 3                                    **INGS TO STRENGTHENING THE FINANCIAL** 4                                    **SOLVENCY OF THE FEDERAL HOSPITAL IN-** 5                                    **SURANCE TRUST FUND.**

6            The third sentence of section 1817(a) of the Social  
7 Security Act (42 U.S.C. 1395(i)) is amended—

8                    (1) in paragraph (1), by striking “and” at the  
9            end;

10                   (2) in paragraph (2), by striking the period at  
11            the end and inserting “; and”; and

12                   (3) by adding at the end the following:

13                   “(3) the revenues made available as a result of  
14            the amendments to title XIX and the Internal Rev-  
15            enue Code of 1986 made by the Universal Health  
16            Care Choice and Access Act (as determined by the  
17            Secretary of the Treasury).”.

## 18      **SEC. 802. HEALTH CARE CHOICE FOR VETERANS.**

19            Beginning not later than 2 years after the date of  
20 the enactment of this Act, the Secretary of Veterans Af-  
21 fairs shall—

22                   (1) permit veterans, and survivors and depend-  
23            ents of veterans, who are eligible for health care and  
24            services under the laws administered by the Sec-  
25            retary to receive such care and services through such

1 non-Department of Veterans Affairs providers and  
2 facilities as the Secretary shall approve for purposes  
3 of this section; and

4 (2) pursuant to such procedures as the Sec-  
5 retary of Veteran Affairs shall prescribe for purposes  
6 of this section, make payments to such providers  
7 and facilities for the provision of such care and serv-  
8 ices to veterans, and such survivors and dependents,  
9 at such rates as the Secretary shall specify in such  
10 procedures and in such manner so that the Sec-  
11 retary ensures that the aggregate payments made by  
12 the Secretary to such providers and facilities do not  
13 exceed the aggregate amounts which the Secretary  
14 would have paid for such care and services if this  
15 section had not been enacted.

16 **SEC. 803. HEALTH CARE CHOICE FOR INDIANS.**

17 (a) IN GENERAL.—Beginning not later than 2 years  
18 after the date of enactment of this Act, the Secretary of  
19 Health and Human Services shall—

20 (1) permit Indians who are eligible for health  
21 care and services under a health care program oper-  
22 ated or financed by the Indian Health Service or by  
23 an Indian Tribe, Tribal Organization, or Urban In-  
24 dian Organization (and any such other individuals  
25 who are so eligible as the Secretary may specify), to

1 receive such care and services through such non- In-  
2 dian Health Service, Indian Tribe, Tribal Organiza-  
3 tion, or Urban Indian Organization providers and  
4 facilities as the Secretary shall approve for purposes  
5 of this section; and

6 (2) pursuant to such procedures as the Sec-  
7 retary of Health and Human Services shall prescribe  
8 for purposes of this section, make payments to such  
9 providers and facilities for the provision of such care  
10 and services to Indians and individuals described in  
11 paragraph (1), at such rates as the Secretary shall  
12 specify in such procedures and in such manner so  
13 that the Secretary ensures that the aggregate pay-  
14 ments made by the Secretary to such providers and  
15 facilities do not exceed the aggregate amounts which  
16 the Secretary would have paid for such care and  
17 services if this section had not been enacted.

18 (b) DEFINITIONS.—In this section, the terms “In-  
19 dian”, “Indian Health Program”, “Indian Tribe”, “Tribal  
20 Organization”, and “Urban Indian Organization” have  
21 the meanings given those terms in section 4 of the Indian  
22 Health Care Improvement Act.

○